

### Instructions for filling out the form:

#### Neurological Medical Record Release Form

We will send this form to your neurologist so that we may obtain medical records that are crucial to the success of the study.

- Fill in your name, date of birth, and your mailing address.
- Sign and date the form.
- Fill in your neurologist's name, address, phone number, and fax number.

\*\*\* After filling out the "Neurological Medical Record Release Form", you must also fill out the "Authorization for Release of Protected or Privileged Health Information Form" that follows (below).

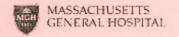
**Both** forms must be returned to the Registry in order to be included in the study.

We greatly appreciate your time and effort in completing these forms and returning them to:

The North American AED Pregnancy Registry Massachusetts General Hospital 125 Nashua Street, Ste 8438 Boston, MA 02114

If you have any questions while filling out this form, or need help, please call the AED Pregnancy Registry (TOLL FREE) 1-888-233-2334. Please have healthcare provider fax records to 617-643-0071.

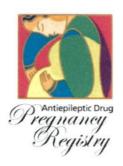






#### MEDICAL RECORD RELEASE

TO WHOM IT MAY CONCERN:		
I hereby request release of all neurologic	al records and information concerningto:  (patient's name)	
Lewis B. Holmes, MD Director AED Pregnancy Registry 125 Nashua Street, Suite 8438 Boston, MA 02114	(patient's name)	
*Patient's Date of Birth: (MM/DD/YY)/		
Patient's Address:		
Patient's Signature:	Today's Date://	
Name of Neurologist:		
Neurologist's Address:		
Neurologist's Telephone: (including area code)	Neurologist's Fax: (including area code)	



### Instructions for filling out the form:

### Authorization for Disclosure of Medical Information From Another Facility

(Adult version)

This form complies with the Health Information Portability and Accountability Act (HIPAA). It is the national standard to protect the privacy of all health information, which is required by all hospitals and physicians' offices to have on file.

- Please complete the information in the box at the top of page 1.
- Please fill in your name above "(Patient Name)". Then fill in the name of either the physician or the health center where care is provided above "(Facility)".
- On page 2, please initial for the release of genetic test results and psychotherapy in the second box, if you wish to authorize the release of this information.
- Sign and date at the bottom of page 2.

We greatly appreciate your time and effort in completing these forms and returning them to:

The North American AED Pregnancy Registry Massachusetts General Hospital 125 Nashua Street, Ste 8438 Boston, MA 02114

If you have any questions while filling out this form, or need help, please call the AED Pregnancy Registry (TOLL FREE) 1-888-233-2334. Please have healthcare provder fax records to 617-643-0071.



## AUTHORIZATION FOR RELEASE OF PROTECTED OR PRIVILEGED HEALTH INFORMATION

RELEASE COPIES OF HEALTH/MEDICAL RECORD
REVIEW HEALTH/MEDICAL RECORD
OBTAIN COPIES OF HEALTH/MEDICAL RECORD FROM ANOTHER FACILITY

PATIENT NAME:	PATIENT DATE OF BIRTH:			
PATIENT MEDICAL RECORD #	(IF ADD	RESSOGRAPH STAMP IS NOT US	ED)	
PATIENT ADDRESS: STREET:			APT. #:	
Сіту:		STATE:	ZIP CODE:	
TELEPHONE CONTACT #: DAY: (				
,	do hereby authorize		to release	
(Patient Name)	do notoby dutitorize	(Facility)		
my protected health information including	g copies of my medical re	cord of care received at	(Fasility/Daster)	
o the following persons at the locations/				
	acility/Address and address)		Purpose (check the appropriate box)	
(include name	and address)	(спеск тпе	appropriate box)	
I	2.	☐ Medic		
LEWIS B. HOLMES, M.D.				
AED PREGNANCY REGISTRY		Legal		
		☐ School		
125 NASHUA STREET, STE 8438			(please specify)*	
BOSTON, MA 02114		RES	EARCH	
2001011, 1112102111				
Please refer to the Partners HealthCar			ay be associated with this	
request. ** There may be additional co	harges for copies of photo	ographs.		
NFORMATION TO BE RELEASED	(Please check all tha	nt apply and specify date	s):	
▼ Clinic visit notes		Photographs**		
☑ Discharge Summary		Radiation reports		
✓ Lab Reports		X-rays/Scan reports		
Operative Reports		Other (please specify)		
Pathology Reports				
	Physical Operative Pepert	Consults Test Reports Dischar	ge Summary)	
Medical Record Abstract (e.g. History & P	Hysical, Operative nepolit.			
Medical Record Abstract (e.g. History & F	nysical, Operative neport, C	oriodito, rest rieporto, bisoriar	,	

# AUTHORIZATION FOR RELEASE OF SPECIFICALLY PROTECTED OR PRIVILEGED INFORMATION

Information Released/Reviewed By: \_

Clinic/Office:

I request	the release of the specific categories of information that I have INITIALED below:
	HIV test results (PATIENT AUTHORIZATION REQUIRED FOR EACH RELEASE REQUEST.)  SPECIFY DATES
	Genetic test results (excludes therapeutic genetic tests)
N/A	(SPECIFY TYPE OF TEST)  Alcohol and Drug Abuse Records Protected by Federal Confidentiality Rules 42 CFR Part 2  (FEDERAL RULES PROHIBIT ANY FURTHER DISCLOSURE OF THIS INFORMATION UNLESS FURTHER DISCLOSURE IS EXPRESSLY PERMITTED OR WRITTEN CONSENT OF THE PERSON TO WHOM IT PERTAINS OR AS OTHERWISE PERMITTED BY 42 CFR PART 2.)
	Other(s): Please List
Confidenti	ial Details of:
	Psychotherapy (from a Psychiatrist, Psychologist, or Mental Health Clinical Nurse Specialist) Social Work Counseling/Therapy Domestic Violence Victims' Counseling Sexual Assault Counseling
Manager  tu ity  I may ref enrollmer Informati HealthCa I underst	thdraw my authorization at any time by submitting a written request to the Director of Health Information ment, or the Office Manager in my Doctor's Office. Authorization may be withdrawn except for the following: to the extent that action has been taken in reliance on this authorization. If the authorization is obtained as a condition of obtaining insurance coverage, other laws provide the insurer with the right to contest a claim under the policy fuse to sign this authorization. If I refuse to sign this authorization, my treatment, payment, health plan ent, or eligibility for benefits will not be affected ion released on this authorization, if redisclosed by the recipient, is no longer protected by Partners are.  It and that this authorization will automatically expire in 6 months unless otherwise specified:
expressly and	ully read and understand the above, have had any questions explained to my satisfaction, and do herein d voluntarily authorize disclosure of the above information about, or medical records of, my condition to those gencies listed above.
Patient's Sig	gnature: Date:
When patient	t is a minor, or is not competent to give consent, the signature of a parent, guardian, or other legal ve is required.
Signature of	f Legal Representative: Date:
Print Name:	Relationship of representative to patient:
	For Internal Use Only

Date: