

Instructions for filling out the form:

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

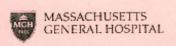
Both forms must be returned to the Registry in order to be included in the study.

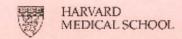
We greatly appreciate your time and effort in completing these forms and returning them to:

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.

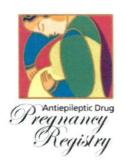






MEDICAL RECORD RELEASE

TO WHOM IT MAY CONCERN:				
I hereby request release of all ob	estetrical records and information concerning	(patient's name)	to:	
Lewis B. Holmes, MD Director AED Pregnancy Registry 125 Nashua Street, Suite 8438 Boston, MA 02114				
*Patient's Date of Birth: (MM/DD/YY)				
Patient's Address:				
_				
Patient's Signature:	Today's Date:	//		
Name of Obstetrician:				
Obstetrician's Address:				
Obstetrician's Telephone:	Obstetrician'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.

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

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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	DRESSOGRAPH STAMP IS NOT USED)		
PATIENT ADDRESS: STREET:	APT. #:		
CITY:	STATE: ZIP CODE:		
TELEPHONE CONTACT #: DAY: ()			
I, do hereby authorize	e to release		
(Patient Name) my protected health information including copies of my medical re			
to the following persons at the locations/facilities listed below, for			
Person(s)/Facility/Address (include name and address)	Purpose (check the appropriate box)		
1. LEWIS B. HOLMES, M.D.	☐ Medical Care ☐ Insurance*		
AED PREGNANCY REGISTRY			
125 NASHUA STREET, STE 8438			
BOSTON, MA 02114	RESEARCH		
* Please refer to the Partners HealthCare Privacy Notice for inforrequest. ** There may be additional charges for copies of photon			
INFORMATION TO BE RELEASED (Please check all the	nat apply and specify dates):		
Image: X	☐ Photographs**		
☑ Discharge Summary	☐ Radiation reports		
■ Lab Reports	X-rays/Scan reports		
☑ Operative Reports	Other (please specify)		
Pathology Reports			
Medical Record Abstract (e.g. History & Physical, Operative Report, Consults, Test Reports, Discharge Summary)			

AUTHORIZATION FOR RELEASE OF SPECIFICALLY PROTECTED OR PRIVILEGED INFORMATION

Clinic/Office: _

I reques	st the release of the specific categories of information that I have INITIALED below:
N/A	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)
IVA	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
Confide	ntial Details of:
	Psychotherapy (from a Psychiatrist, Psychologist, or Mental Health Clinical Nurse Specialist)
	Social Work Counseling/Therapy
	Domestic Violence Victims' Counseling
	Sexual Assault Counseling
I may enrollr Inform Health I unde I have care expressly	withdraw my authorization at any time by submitting a written request to the Director of Health Information gement, 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 refuse to sign this authorization. If I refuse to sign this authorization, my treatment, payment, health plan ment, or eligibility for benefits will not be affected action released on this authorization, if redisclosed by the recipient, is no longer protected by Partners in Care. First and that this authorization will automatically expire in 6 months unless otherwise specified: Fully read and understand the above, have had any questions explained to my satisfaction, and do herein and voluntarily authorize disclosure of the above information about, or medical records of, my condition to those ragencies listed above.
Patient's	Signature: Date:
Print Nam	ne:
When pati	ient is a minor, or is not competent to give consent, the signature of a parent, guardian, or other legal ative is required.
Signature	e of Legal Representative: Date:
Print Nam	ne: Relationship of representative to patient:
	For Internal Use Only
Information F	Released/Reviewed By: Date: