

Instructions for filling out the form: Pediatric Medical Record Release Form

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

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

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

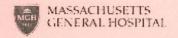
Both forms must be returned to the Registry in order to be included in the study.

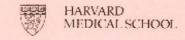
We greatly appreciate your time and effort in completing these forms and returning them to:

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.



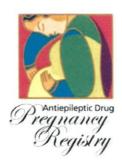




MEDICAL RECORD RELEASE

TO WHOM IT MAY CON	CERN:			
I hereby request release of all	pediatric records and information conce	erning	(*baby's name)	to:
Lewis B. Holmes, MD Director AED Pregnancy Registry 125 Nashua Street, Suite 843 Boston, MA 02114	8			
* Patient's Date of Birth: (MM/DD/YY)	/			
Patient's Address:				
Patient's Mother's Name:				
Mother's Date of Birth: (MM/DD/YY)	//			
Mother's Signature:		Today's Date:	//	
Name of Pediatrician:				
Pediatrician's Address:				
Pediatrician's Telephone: (including area code)		rician's Fax:		

*If you are still currently pregnant, please leave these fields blank. They will be completed at your follow-up interview.



Instructions for filling out the form:

Authorization for Disclosure of Medical Information From Another Facility (Child version)

This form is also known as 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 for your child in the box at the top of page 1.
- Please fill in your child's 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 your name at the bottom of page 2 next to "Signature of Legal Representative".

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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.



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 ADDRES	SSOGRAPH STAMP IS NOT LISED)			
(IF ADDRESSOGRAFT STAWF IS NOT USED)				
PATIENT ADDRESS: STREET:	APT. #:			
CITY:	STATE: ZIP CODE:			
TELEPHONE CONTACT #: DAY: ()	_ EVENING: ()			
I. do hereby authorize	to release			
I, do hereby authorize (Patient Name)				
my protected health information including copies of my medical record to the following persons at the locations/facilities listed below, for the	rd of care received at(Facility/Doctor)			
Person(s)/Facility/Address	Purpose			
(include name and address)	(check the appropriate box)			
1. LEWIS B. HOLMES, M.D.	☐ Medical Care ☐ Insurance*			
AED PREGNANCY REGISTRY	☐ Legal Matter* ☐ Personal*			
	☐ School			
125 NASHUA STREET, STE 8438	Sther (please specify)* RESEARCH			
BOSTON, MA 02114	RESEARCH			
* Please refer to the Partners HealthCare Privacy Notice for information on copying fees that may be associated with this request. ** There may be additional charges for copies of photographs. INFORMATION TO BE RELEASED (Please check all that apply and specify dates):				
	Photographs**			
	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

Information Released/Reviewed By: _

Clinic/Office: _

I request the relea	se of the specific categories of information that I have INITIALED below:			
	HIV test results (PATIENT AUTHORIZATION REQUIRED FOR EACH RELEASE REQUEST.) SPECIFY DATES			
	st results (excludes therapeutic genetic tests)			
	TYPE OF TEST)			
(FEDERAL DISCLOSUI	nd Drug Abuse Records Protected by Federal Confidentiality Rules 42 CFR Part 2 RULES PROHIBIT ANY FURTHER DISCLOSURE OF THIS INFORMATION UNLESS FURTHER RE IS EXPRESSLY PERMITTED OR WRITTEN CONSENT OF THE PERSON TO WHOM IT PERTAINS HERWISE PERMITTED BY 42 CFR PART 2.)			
Other(s):	Please List			
Confidential Details	of:			
Social Wo	erapy (from a Psychiatrist, Psychologist, or Mental Health Clinical Nurse Specialist) ork Counseling/Therapy Violence Victims' Counseling esault Counseling			
Management, or the to the exten if the author with the righ I may refuse to sign enrollment, or eligib Information released HealthCare. I understand that thi	authorization at any time by submitting a written request to the Director of Health Information of Office Manager in my Doctor's Office. Authorization may be withdrawn except for the following: at that action has been taken in reliance on this authorization. Arization is obtained as a condition of obtaining insurance coverage, other laws provide the insurer at to contest a claim under the policy this authorization. If I refuse to sign this authorization, my treatment, payment, health plan ility for benefits will not be affected d on this authorization, if redisclosed by the recipient, is no longer protected by Partners is authorization will automatically expire in 6 months unless otherwise specified:			
	d understand the above, have had any questions explained to my satisfaction, and do herein y authorize disclosure of the above information about, or medical records of, my condition to those ed above.			
Patient's Signature:	Date:			
Print Name:				
	, or is not competent to give consent, the signature of a parent, guardian, or other legal ed.			
Signature of Legal Rep	presentative: Date:			
Print Name:	Relationship of representative to patient:			
	For Internal Use Only			

Date: _