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 CONCERN:

I hereby request release of all pediatric records and information concerning (*) baby'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 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: ___________________________     Pediatrician's Fax: ___________________________
(including area code)     (including area code)

*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”.

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.
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 ADDRESSOGRAPH STAMP IS NOT USED)

PATIENT ADDRESS:  STREET: ___________________________  APT. #: ______

CITY: ___________________________  STATE: ______  ZIP CODE: ______

TELEPHONE CONTACT #:  DAY: ( ) _____________  EVENING: ( ) _____________

I, ___________________________ (Patient Name) do hereby authorize ___________________________ (Facility) to release my protected health information including copies of my medical record of care received at ___________________________ (Facility/Doctor) to the following persons at the locations/facilities listed below, for the purposes described: ___________________________ (Facility/Doctor)

Person(s)/Facility/Address  Purpose
(include name and address)  (check the appropriate box)

1.  LEWIS B. HOLMES, M.D.  ? Medical Care
    AED PREGNANCY REGISTRY  ? Insurance*
    125 NASHUA STREET, STE 8438  ? Legal Matter*
    BOSTON, MA 02114  ? Personal*

☐ School  ☑ Other (please specify)*
        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):

☑ Clinic visit notes  ☐ 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)

See Page 2 on Reverse
AUTHORIZATION FOR RELEASE OF SPECIFICALLY PROTECTED OR PRIVILEGED INFORMATION

I request 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)
(SPECIFY TYPE OF TEST) ____________________________

N/A 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 ____________________________

Confidential 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 understand that:

• I may withdraw my authorization at any time by submitting a written request to the Director of Health Information Management, 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

• I may refuse to sign this authorization. If I refuse to sign this authorization, my treatment, payment, health plan enrollment, or eligibility for benefits will not be affected

• Information released on this authorization, if disclosed by the recipient, is no longer protected by Partners HealthCare.

• I understand that this authorization will automatically expire in 6 months unless otherwise specified:

I have carefully read and understand the above, have had any questions explained to my satisfaction, and do herein expressly and voluntarily authorize disclosure of the above information about, or medical records of, my condition to those persons or agencies listed above.

Patient's Signature: ____________________________  Date: ____________________________

Print Name: ____________________________
When patient is a minor, or is not competent to give consent, the signature of a parent, guardian, or other legal representative is required.

Signature of Legal Representative: ____________________________  Date: ____________________________

Print Name: ____________________________  Relationship of representative to patient: ____________________________

For Internal Use Only

Information Released/Reviewed By: ____________________________  Date: ____________________________

Clinic/Office: ____________________________  Date: ____________________________