BERKSHIRE OB/GYN ASSOCIATES, P.C.
PO BOX 1690, PITTSFIELD, MA 01202
PHONE: 413-499-8570 FAX: 413-499-8565

Authorization for Release of Medical Record Information

I hereby authorize Berkshire OB/GYN Associates, P.C. to use or disclose the specific information described below, only for the purposes and parties also described below.

Patient Name: _____
Last First M.I.

Home Address: _____

_____

Home Phone: _____ Date of Birth: _____

I Authorize Doctor(s) _____
To send copies of my Medical Record to:

Name: _____

Address: _____

_____

Covering Records for the Period From_____ To _____
Or
Confined to the Following Specified Information _____

_____

☐ No limitations placed on dates, history of illness, or diagnostic or therapeutic information, including treatment for alcohol abuse, drug abuse, and sexual abuse.
(Patient initials) _____

☐ This authorization shall remain in effect from the date signed below until _____ (Expiration date).

I understand that:

- I may inspect or copy the information to be used or disclosed
- I may revoke this authorization in writing by contacting your office at the address above, attention Privacy Officer
- Information used or disclosed pursuant to the authorization may be subject to re-disclosure by the recipient and no longer be protected by HIPAA
- I may refuse to sign this authorization and that you will not condition treatment to payment on me providing this authorization (except to the extent that the authorization is for research-related treatment, in which case you may refuse to provide that research-related treatment

☐ If this box is checked, I understand that you will receive compensation from a third party for the use or disclosure of my information.

Patient Signature: _____ Date: _____

Relation ship to patient (if signed by personal representative of patient)_____

Witness: _____