Medical Records Release Form

Name:_____DOB:_____Phone:_____

Address:_____City/State/Zip:_____

***I authorize*: Birth & Beyond**
411 Durham Road, Madison, CT 06443
Phone: 203-318-8884 Fax: 203-318-8886

◯ ***To release*** ◯ ***To obtain*** ***My***: ◯ Current pregnancy records ◯ GYN records
◯ Prior pregnancy(ies) records ◯ All records
◯ Other: _____

To/from: Other Provider/Organization:_____

Address:_____City/State/Zip:_____

Phone:_____Fax:_____

Reason for disclosure: ◯ Changing provider ◯ Seeking second opinion
◯ Insurance change ◯ Moving ◯ Personal use
◯ Dissatisfied with care ◯ Legal ◯ Other: _____

- *I understand that I may revoke this Authorization at any time by providing written notice to Birth & Beyond, Inc. I understand that I may not be able to revoke this Authorization if Birth & Beyond, Inc. has taken action in reliance on the Authorization, or if the Authorization was obtained as a condition of obtaining insurance coverage.*
- *I understand that Birth & Beyond, Inc. will not condition treatment, payment, enrollment, or eligibility for benefits based on my signing this Authorization. I acknowledge that I am signing this Authorization freely, and no one has coerced or pressured me into signing it.*
- *I understand that the protected health information disclosed under this Authorization may be subject to redisclosure by the recipient and no longer protected by the federal Privacy Regulations.*
- *I also understand that if the personal health information that is disclosed under this Authorization is related to HIV/AIDS, or alcohol or drug abuse, that Birth & Beyond, Inc. may not redisclose that information under Connecticut state law.*
- *I acknowledge that I have carefully reviewed this Authorization and understand its provisions. I may request a copy of this executed agreement.*

Signature:_____**Date**:_____