

Authorization for Use or Disclosure of Information for Purposes Requested by Physician's Office

Max Chorowski, MD
 The Counseling & Gynecology Group, P.C.
 175 Dwight Road, Suite 103, Longmeadow, MA 01106
 413-567-9355

Patient Information		
Patient Full Name: _____	Date of Birth: _____	
Address: _____	Home Phone: _____	
City & State: _____	Zip: _____	Work Phone: _____

Release of Information		
I hereby authorize The Counseling & Gynecology Group to:		
<input type="checkbox"/> Mail Copies of my Medical Information to:	<input type="checkbox"/> Hold for Patient Pick-up	<input type="checkbox"/> Discuss Medical Record Information With:
		<input type="checkbox"/> To obtain my individually identifiable health records from:
Name/Facility: _____	Attention: _____	
Address: _____	Phone: _____	
City: _____	State: _____	Zip: _____
		Fax: _____
Purpose of Request:		
<input type="checkbox"/> Personal	<input type="checkbox"/> Continuing Care	<input type="checkbox"/> Legal
<input type="checkbox"/> Insurance	<input type="checkbox"/> Other: _____	
COPY FEE: we reserve the right to charge a reasonable fee for the cost of producing and mailing the copies.		

Information to be Released	PLEASE BE SPECIFIC- include dates of treatment & provider name if applicable.
_____	Date(s) of Treatment _____
_____	Date(s) of Treatment _____

Authorization for Release of Statutorily Protected (sensitive) Information		
DO NOT Leave This Section Blank- the requested medical record MAY or MAY NOT contain information that is statutorily protected. You must check either "Yes" or "No" and initial each category for The Counseling & Gynecology Group to properly process your medical record request.		
Do you authorize The Counseling & Gynecology Group to release the following medical information? Check "yes" or "no".		
	Yes Or No	
Mental Health	<input type="checkbox"/> <input type="checkbox"/>	Initial Here: _____
Alcohol and/or Substance Abuse	<input type="checkbox"/> <input type="checkbox"/>	Initial Here: _____
Abortion	<input type="checkbox"/> <input type="checkbox"/>	Initial Here: _____
Genetic Testing	<input type="checkbox"/> <input type="checkbox"/>	Initial Here: _____
Sexually Transmitted Diseases (Including information on HIV & AIDS)	<input type="checkbox"/> <input type="checkbox"/>	Initial Here: _____

This authorization shall be in force and effect for two years or until _____ (date), at which time this authorization to use or disclose this protected health information expires.

I understand that I have the right to revoke this authorization, in writing, at any time by sending such written notification to the Privacy Officer at The Counseling & Gynecology Group, P.C 175 Dwight Rd., Longmeadow, MA 01106. I understand that a revocation is not effective to the extent that The Counseling & Gynecology Group, P.C. has relied on the use or disclosure of the protected health information.

I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law.

The Counseling & Gynecology Group, P.C. will not condition treatment on payment of the provision of this Authorization.

I understand that I have the right to inspect or copy the protected health information to be used or disclosed as permitted under federal law (or state law to the extent the state law provides greater access rights), or Refuse to sign this authorization.

_____ Patient's Signature	_____ Date
_____ Parent/Legally Recognized Representative Signature	_____ Date
_____ Witness	_____ Date