

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:

AED Pregnancy Registry Massachusetts General Hospital 121 Innerbelt Road, Room 220 Somerville, MA 02143

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**.



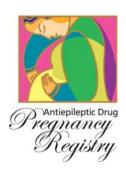




MEDICAL RECORD RELEASE

TO WHOM IT MAY CONCERN:					
I hereby request release of all pediatric to:	ion concerning	(*baby's name)			
Lewis B. Holmes, MD Director AED Pregnancy Registry 121 Innerbelt Road, Room 220 Somerville, MA 02143					
* 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)				

*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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AUTHORIZATION FOR RELEASE OF PROTECTED OR PRIVILEGED HEALTH INFORMATION

RELEASE COPIES OF REVIEW HEALTH/ME OBTAIN COPIES OF FACILITY	DICAL	RECORD		OTHER					
PATIENT NAME:					PATIENT DATE OF BIRTH:				
PATIENT MEDICAL RE	CORE) #		_ (IF ADDRESS	SOGRAPH STAMP	IS NOT US	ED)		
PATIENT ADDRESS: STREET:				Арт. #:					
	CITY	/:			STATE:		ZIP CODE		
TELEPHONE CONTACT	#:	DAY: ()		EVENING: ()_			
I,			do hereby	authorize				to release	
I,(Patien my protected health info to the following persons	ormat	ion including	copies of my n	nedical record	d of care receive	ed at			
to the following persons			cility/Address	,		Purpose	appropriate box)		
			2.			Medic Insura Legal Perso School	ance* Matter* onal*)* 	
* Please refer to the Prequest. ** There ma	ay be	additional ch	arges for copie	s of photogra	phs.			ed with this	
Clinic visit notes				_ 🗇 F	Photographs**				
Discharge Summary _				F	Radiation reports				
Lab Reports				>	X-rays/Scan reports				
Operative Reports					1 Other (please specify)				
Pathology Reports				_					
Medical Record Abstra	ict (e.	g. History & Pi	hysical, Operative	e Report, Cons	sults, Test Reports	s, Dischar	ge Summary)		

AUTHORIZATION FOR RELEASE OF SPECIFICALLY PROTECTED OR PRIVILEGED INFORMATION

Information Released/Reviewed By:

Clinic/Office: _

I request the release of the specific categories of information that I have INITIA	A <i>LED</i> below:
HIV test results (PATIENT AUTHORIZATION REQUIRED FOR EACH RELEASE REQUEST.))
SPECIFY DATES Genetic test results (excludes therapeutic genetic tests)	
(SPECIFY TYPE OF TEST)	
Alcohol and Drug Abuse Records Protected by Federal Confidentiality Rules 42 CFR (FEDERAL RULES PROHIBIT ANY FURTHER DISCLOSURE OF THIS INFORMATION UNLESS DISCLOSURE IS EXPRESSLY PERMITTED OR WRITTEN CONSENT OF THE PERSON TO WOR AS OTHERWISE PERMITTED BY 42 CFR PART 2.)	S FURTHER
Other(s): Please List	
Confidential Details of:	
Psychotherapy (from a Psychiatrist, Psychologist, or Mental Health Clinical Nurs Social Work Counseling/Therapy Domestic Violence Victims' Counseling Sexual Assault Counseling	e Specialist)
 I understand that: I may withdraw my authorization at any time by submitting a written request to the Director of Heat Management, or the Office Manager in my Doctor's Office. Authorization may be withdrawn exce 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 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 enrollment, or eligibility for benefits will not be affected Information released on this authorization, if redisclosed by the recipient, is no longer protected by HealthCare. I understand that this authorization will automatically expire in 6 months unless otherwise specifies 	pt for the following: provide the insurer nt, health plan y Partners
I have carefully read and understand the above, have had any questions explained to my satisfaction, expressly and voluntarily authorize disclosure of the above information about, or medical records of, necessary 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 o representative is required.	ther legal
Signature of Legal Representative: Date:	
Print Name: Relationship of representative to pation	ent:
For Internal Use Only	

Date: ____