



**OBSTETRICS & GYNECOLOGY**

Abraham Fischer, MD  
Diane Pingeton, MD  
Diego Illanes, MD  
Dina M. Deldon-Saltin, DO  
Elizabeth A. Kopin, MD  
Jaimee DeMone, MD  
June O'Connor-Ramsaran, MD  
Kerri E. Osterhaus-Houle, MD  
Meredith A. Kern, MD  
Peter C. Davidow, MD  
Stanley Surette, MD

**Marlborough Office:** 340 Maple St., Suite 125, Marlborough, MA, 01752  
Phone: 508-485-1056 Fax: 508-460-6588

**AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION**

Patient's Name: \_\_\_\_\_ Date of Birth/  
Social Security  
#: \_\_\_\_\_ / \_\_\_\_\_  
Previous Name: \_\_\_\_\_ Address: \_\_\_\_\_

I request and authorize \_\_\_\_\_

to release healthcare information of the patient named above to:

Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

This request and authorization applies to:

Healthcare information relating to the following treatment, condition, or dates: \_\_\_\_\_

All healthcare information

Other: \_\_\_\_\_

Reason for Request: \_\_\_\_\_

Leaving Practice:  Yes  No

Physician's Signature: \_\_\_\_\_

**Definition:** Sexually Transmitted Disease (STD) as defined by law, RCW 70.24 et seq., includes herpes, herpes simplex, human papilloma virus, wart, genital wart, condyloma, Chlamydia, non-specific urethritis, syphilis, VDRL, chancroid, lymphogranuloma venereum, HIV (Human Immunodeficiency Virus), AIDS (Acquired Immunodeficiency Syndrome), and gonorrhea.

Yes  No I authorize the release of my STD results, HIV/AIDS testing, whether negative or positive, to the person(s) listed above. I understand that the person(s) listed above will be notified that I must give specific written permission before disclosure of these test results to anyone.

Yes  No I authorize the release of any records regarding drug, alcohol, or mental health treatment to the person(s) listed above.

Patient Signature: \_\_\_\_\_ Date  
Signed: \_\_\_\_\_

THIS AUTHORIZATION EXPIRES NINETY DAYS AFTER IT IS SIGNED.