



Wellesley Women's Care, P.C.
2000 Washington Street, Ste. 764
Newton, MA 02462
Phone: 617-965-7800 ~ Fax: 617-965-4581

**Authorization of Disclosure Protected Health Information by another Covered Entity
For Use by Wellesley Women's Care, P.C.**

Patient Name: _____ **DOB:** _____

Patient's Address: _____

Information to Be Used or Disclosed

Information covered by this authorization includes:

Complete Record: _____ Specific Record: _____
Sensitive Information: _____ Abortion _____ Abuse _____ AIDS/ARC _____ Alcohol Abuse _____ Hepatitis _____ Infertility
_____ Mental Health Visits _____ Sexual Abuse/Assault/Rape _____ Substance Abuse
_____ Other (Please Specify) _____

Persons of Disclosure

Information listed above will be disclosed for the following purposes:

_____ Transferring to Wellesley Women's Care _____ Referred to Wellesley Women's Care
_____ 2nd Opinion/Consult/Referral _____ Other (Please Specify) _____

Persons Authorized to Use or Disclose Information

Information listed above will be **disclosed by:**

Provide the Address or Fax number to where you would like your records released from.

Name of person/Organization

Street Address

or fax number

City, State, Zip Code

Persons to Whom Information May Be Disclosed

**Wellesley Women's Care, P.C.
2000 Washington Street, Suite 764
Newton, MA 02462**

Or record can be faxed to 617-965-4581

Expiration Date of Authorization

This authorization is effective through ____/____/____ unless revoked or terminated by the patient or the patient's personal representative.

Signature

Name of Patient (print or type)

Signature of Patient

Date