WOMEN'S HEALTH ASSOCIATES OF CAPE COD, INC.
GYNECOLOGY
46 NORTH STREET
HYANNIS, MASSACHUSETTS 02601

TELEPHONE 508-771-7100
FAX 508-771-1447

GERALYN LEONE, M.D., F.A.C.O.G.

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

I, _____ D.O.B. _____,
(Name)

give permission to:_____
(name of doctor)

to disclose the following protected health information to:

Dr Geralyn Leone
Women's Health Associates of Cape Cod
46 North Street, Hyannis, MA 02601
V) 508-771-7100 F) 508-771-1447

Information to be disclosed (check all that apply):

__ Medical Records (all)
__ Treatment Records
__ Diagnostic Records
__ Other: _____

This protected health information is being used or disclosed for the following purposes:

Continuity of care

This authorization expires six months from today. _____
(date)

If the person or entity receiving this information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be disclosed to other individuals or institutions and no longer protected by these regulations.

You may refuse to sign this authorization. Your refusal to sign will not affect your ability to obtain treatment or payment or your eligibility for benefits.

You may inspect or copy the protected health information to be used or disclosed under this authorization. For protected health information created as part of a clinical trial, your right to access is suspended until the clinical trial is completed.

Finally, you may revoke this authorization in writing at any time by sending written notification to Women's Health Associates. Your notice will not apply to actions taken by the requesting person/entity prior to the date they receive your written request to revoke authorization.

_____
Signature of Participant or Personal Representative

_____
Date

_____
Printed Name of Participant or Personal Representative

_____
Description of Personal Representative's Authority