Form Approved
OMB No. 0920-0010
Exp. Date: 01/31/2017

Birth Defects Study To Evaluate Pregnancy exposureS (BD-STEPS)

Health Insurance Portability and Accountability Act (HIPAA) **Medical Records Release Authorization Form**

Patient Name: Click here to enter text.	
Phone number(s): Click here to enter text.	**Street Address:** Click here to enter text.
Date of Birth:	

1. I authorize the use or disclosure of the above named individual's health information as described below.

2. I authorize the following individuals and/or organizations to make this disclosure.

   Click here to enter text.

3. Provider type listed above *(if more than one category applies such as prenatal and infertility, check all that apply).*

Provider Types *(Check if Mother's name provided as Patient Name)*

☐ Prenatal care provider
☐ Infertility specialists or other provider seen for infertility-related reasons
☐ Dentist or oral care provider

The information identified below may be used by or disclosed to the following individuals/organizations:

Name: Birth Defects Study To Evaluate Pregnancy exposureS (BD-STEPS)

Address: INSERT LOCAL ADDRESS of CBDRP

Check Either 4 or 5

4. ☐ **I Authorize Release of the ENTIRE medical record without exception** . If you checked, #4, ENTIRE record, please proceed to #6.
5. ☐ **I Authorize Release of PARTIAL medical records. If you checked #5, PARTIAL release, please specify the parts and dates to be released below**.

Dates of Service I authorize for release:

Click here to enter text. To Click here to enter text.

Types of information I authorize for release (check all that you authorize)

☐Consultation Reports	☐Pathology Report	☐Progress Notes
☐Lab Results	☐Post-Operative Reports	☐Radiology (Ultrasound) Reports
☐Medication List	☐Procedural Information	

6. The information that I am allowing to be released will only be used for the Birth Defects Study To Evaluate Pregnancy exposureS (BD-STEPS), a research study on the causes of birth defects.

7. I understand that I have a right to withdraw this authorization at any time. If I choose to withdraw this authorization, I must do so in writing, and submit my written request to the medical records department of this facility. I also understand that any information that the researchers collect before I choose to withdraw this approval will be kept by the researchers.

8. I understand that unless withdrawn, this authorization will expire at the end of the Birth Defects Study To Evaluate Pregnancy exposureS (BD-STEPS).

9. I understand that because sensitive information is collected in this study, BD- STEPS received a **Certificate of Confidentiality**. This means that any information that identifies me or my child will be used only for this project. It **cannot be given, used, or disclosed** to anyone else unless I give my written consent.

10. I understand that this disclosure is voluntary. My decision to authorize or not authorize the release of this information will not affect my ability to be treated at the above mentioned facilities.

Patient (or legal representative) Signature		Date
If signed by legal representative, relationship to patient		
Signature of Witness (for BD-STEPS staff)		Date