

Authorization for the Release of Medical Information

(Copying Charges: \$20 for 1st 40 pages & \$.25 each add'l page for personal use, insurance, and attorneys)

I hereby authorize and request records to be released for:

Patient's Name: _____ Other names seen under: _____	
Patient's Address: _____	
Phone #: _____	Social Security #: _____ Date of Birth: _____
Chart #: _____ Records Requested for date(s) of _____ to _____	

Records To Be Received From:	Records To Be Sent To:
_____	_____
Health Care Facility or Physician Name	Health Care Facility or Physician Name
_____	_____
Address	Address
_____	_____
City, State & Zip Code	City, State & Zip Code

Authorization applies to the following information: (Check all applicable)				
<input type="checkbox"/> Office Notes	<input type="checkbox"/> Lab Reports	<input type="checkbox"/> HSG Reports	<input type="checkbox"/> Ultrasounds	<input type="checkbox"/> OP Reports
<input type="checkbox"/> H & P's	<input type="checkbox"/> D/C Summary	<input type="checkbox"/> Semen Analysis	<input type="checkbox"/> Misc. Correspondence	

Purpose of Release: (Check Applicable Reason)				
<input type="checkbox"/> Consult (2 nd Opinion)	<input type="checkbox"/> Seeking New Physician	<input type="checkbox"/> Relocation	<input type="checkbox"/> Referral	
<input type="checkbox"/> Dissatisfied with Service	<input type="checkbox"/> Attorney Request	<input type="checkbox"/> Insurance Request	<input type="checkbox"/> Personal Reasons	

Expiration Notice: I understand that this authorization shall expire, without express revocation, when processing is completed and/or 90 days.

Records from other facilities/redisclosure: It is a policy of Fertility Associates of Memphis, PLLC to release only medical information documented, or dictated by Fertility Associates of Memphis, PLLC health care providers. If you have been treated by other health care providers, please contact them and make arrangements to release any information you may need. Federal Regulations prohibit us from making any further disclosure of disclosed information without specific written consent of the person to whom it pertains.

Fertility Associates of Memphis ___ will ___ will not receive payment or other remuneration from a third party other than my insurance in exchange for using or disclosing this Personally Identifiable Health Information. I do not have to sign this authorization in order to receive treatment and may, in fact, refuse to sign.

Signature of Person Authorized (Parent or Legal Guardian) Date

Completed by: _____ Date Mailed: _____ Date of Pick Up/Fax: _____ Paid (if applicable): \$ _____