

## Authorization for the Release of Medical Information

Copying Charges: \$20 for 1<sup>st</sup> 5 pages & \$.50 each additional page for personal use, physician, 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 _____	

<b>Records To Be Sent To:</b>		
_____		
Health Care Facility or Physician Name		
_____		
Address		City, State & Zip Code
_____		
Phone Number	Fax Number	Appointment Date (if applicable)
_____		

<b>Authorization applies to the following information: (Check all applicable)</b>			
<input type="checkbox"/> Office Notes	<input type="checkbox"/> HSG Reports	<input type="checkbox"/> Ultrasounds	<input type="checkbox"/> Semen Analysis
<input type="checkbox"/> OP Reports	<input type="checkbox"/> H & P's	<input type="checkbox"/> D/C Summary	<input type="checkbox"/> Psychotherapy Reports
<input type="checkbox"/> Lab Reports (including genetics/HIV/Hep B)			
<input type="checkbox"/> Donor egg, donor sperm, donor embryo, surrogacy, or gestational carrier			

<b>Purpose of Release: (Check Applicable Reason)</b>			
<input type="checkbox"/> Consult (2 <sup>nd</sup> 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

<b>Expiration Notice: I understand that this authorization shall expire, without express revocation, when processing is completed and/or 90 days.</b>
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<b>Records from other facilities/redislosure:</b> 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. I do not have to sign this authorization in order to receive treatment, in fact, may refuse to sign.
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Signature of Person Authorized ( Parent or Legal Guardian)	Date
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Completed by:	Date Mailed:	Date of Pick Up/Fax:	Paid ( if applicable): \$
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