Fertility & Midwifery Care Center

Patient Name: _____ DOB: _____ MRN: _____

Address: _____

Phone Number: ( ) _____ SSN: _____ - _____ - _____

AUTHORIZATION FOR RELEASE OF PATIENT HEALTH INFORMATION

I hereby authorize that the health information regarding the above named person be forwarded:

FROM: Dr._____

Address: _____ **Fax #:** _____

City: _____ State: _____ Zip Code: _____

TO: Recipient: _____

Address: _____ **Fax#:** _____

City: _____ State: _____ Zip Code: _____

Purpose or need for information: _____

Disclosure will include (*check all that apply)*

☐ Entire Record ☐ Face Sheet ☐ History & Physical ☐ Lab Results ☐ Operative Report ☐ Itemized Bill ☐ Emergency Report

☐ Discharge Summary ☐ Progress/Physician Notes ☐ Nurse Notes ☐ Ultrasound Reports ☐ Pathology Report ☐ Consultation Report

☐ EKG/EMG/EEG Report ☐ Other _____

Records for the period (dates) from _____ to _____

I must check one or more of the following types of health information that I do not want released to the above named Recipient. I understand that if I do not check any of the three (3) boxes, the health information released to the named Recipient may include any of the following:

_____ Diagnosis, Evaluation and/or Treatment for alcohol and/or drug abuse

_____ Records of HTLV-III or HIV testing (AIDS test) results, diagnosis and/or treatment

_____ Psychiatric, psychological records or evaluation and/treatment for mental, physical and/or emotional illness including narrative summary, tests, social work assessment, medication, psychiatric examination, progress notes, consultations, treatment plans, and/or evaluation.

I also understand that this Authorization is subject to revocation/withdrawal by me at any time in writing to the medical record contact person at this site of care except to the extent that action has already been taken to release this information. This Authorization shall remain valid unless revoked but will expire in one (1) year after signing. I have the right to inspect a copy of the health information to be released and if I do not sign this Authorization, the institution named above will not release my health information. The above named person/doctor/institution will not refuse to treat me based on whether I agree to allow my health information to be used and disclosed to others. I hereby hold harmless the releasing party from any legal liability which might arise from such release.

_____ _____

Signature of Patient Date

_____ _____

Signature of Parent/Legal Guardian/Personal Representative
(Required if Patient is not legally authorized to sign Authorization)

Relationship to Patient

_____

Witness