Authorization for the Release of Medical Information

(Copying Charges:$20 for 1st 5 pages & $.50 each addional 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 _____________________

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)

☐ Office Notes ☐ Lab Reports ☐ HSG Reports ☐ Ultrasounds ☐ OP Reports
☐ H & P's ☐ D/C Summary ☐ Semen Analysis ☐ Misc. Correspondence

Purpose of Release: (Check Applicable Reason)

☐ Consult (2nd Opinion) ☐ Seeking New Physician ☐ Relocation ☐ Referral
☐ Dissatisfied with Service ☐ Attorney Request ☐ Insurance Request ☐ 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.

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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): $