The Reproductive Medicine Group
INFERTILITY • REPRODUCTIVE ENDOCRINOLOGY • IVF

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Release of Protected Health Information

Patient Name: _____ **DOB:** _____

Previously known as: _____ **Medical Record #:** _____

I hereby authorize the release of my Protected Health Information (PHI)

☐ From: The Reproductive Medicine Group

To: _____
_____
_____

Date of appointment: _____

☐ To: The Reproductive Medicine Group

From: _____
_____
_____

For the purpose of : ☐ Continuity of care ☐ Personal Records ☐ Transferring Out of Practice

☐ Other, specify: _____

You may disclose the following Protected Health Information: ☐ Complete Medical Records

☐ Progress Notes ☐ Laboratory Reports ☐ Pathology Reports ☐ Surgical Reports

☐ Other, specify: _____

The following information will NOT be released WITHOUT my authorization. I authorize the disclosure of:

☐HIV ☐Genetic Testing ☐ Psychiatric Notes ☐Drug & Alcohol ☐Display Photographs – **Patient Initials: _____**

This authorization ends: ☐ **On date:** _____

☐ This authorization will expire automatically when the records requested on this form have been mailed to the requestor or within180 days from the date of signature, whichever comes first.

The Reproductive Medicine Group reserves the right to charge a fee for copying medical records. The practice will provide the first copy of medical records to the patient in any 12 month period at no charge. It is our policy to release records directly to the patient. Records will be mailed within 7 working days from the date of receipt of a properly executed Release of Protected Health Information authorization.

PATIENT RIGHTS: I understand I do not have to sign this authorization in order to receive health care services. However, I do have to sign an authorization form when the purpose is to provide my Protected Health Information (PHI) to a third party.

I understand that authorization to display photographs listed above authorizes the use of my child/children photographs to be displayed in The Reproductive Medicine Group facilities. I understand all photographs provided to The Reproductive Medicine Group shall be displayed until revocation is received.

I understand that I may revoke this authorization in writing at any time by submitting a written letter to the named practice listed above. If I do, it will not affect any actions already taken.

I understand that once my Protected Health Information (PHI) has been disclosed to the named person/organization in this authorization, Privacy laws may no longer protect it, and the named person/organization may re-disclose it.

_____ _____
Patient or Legal Representative Signature Date Signed

_____ _____
Print Name if signed on behalf of the patient Relationship to Patient