The Reproductive Medicine Group
The Prelude Network®

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION TO OTHER PARTIES

Patient's name: _____ Prior Name, if any: _____
Address: _____ Phone Number: _____
City: _____ State: _____ Zip Code: _____ DOB: _____

PROVIDING PARTY

I hereby authorize The Reproductive Medicine Group to release my health information, including copies of my medical records, to the following person or entity:

_____

Name of Person or Entity | Fax No | Telephone No.

_____

Street | City | State | Zip

PURPOSE OF RELEASE

□ Medical Care □ Legal □ Insurance □ Personal Copy □ Leaving The Reproductive Medicine Group

□ Other:_____

*** If leaving the Clinic, please check the reason(s):**
□ Discharged to Ob-Gyn □ Transfer to another Infertility Center

□ Other:_____

I REQUEST MY RECORDS BE RELEASED VIA (SELECT ONE OPTION)

□ Email: _____

□ Fax: _____

□ Mailed to: _____

INFORMATION TO BE RELEASED

Complete medical record (please select one option below):

□ Complete medical record (please note this will include HIV/AIDS/STD test results/information, Genetic testing information, and Alcohol/Drug Abuse unless expressly requested to be excluded)

Partial Medical record (please select one option below):

□ Obstetrical records only (this will include only bHCG, P4 - progesterone, E2 – estradiol and OB ultrasounds)

□ Other; please specify: _____

□ Billing Records

If you would like the below information to be **excluded** from the medical records, please

select the appropriate check box below, and initial next to it.

□ HIV/AIDS/STD test results/Information

□ Genetic testing information

□ Alcohol/Drug Abuse

□ Behavioral/Mental Health Information

EXPIRATION OF AUTHORIZATION

This authorization will automatically expire one year from the date set forth below unless otherwise specified: _____.
(Date of expiration)

RIGHT TO REVOKE AUTHORIZATION

I understand that I have the right to revoke this authorization at any time by giving written notification to the Clinic. I understand that the revocation will not have any effect on actions taken by the Clinic in reliance on this authorization before it receives my written notice of revocation. I also understand that the revocation will not apply to any health information that has already been released in response to this authorization. Once the Clinic has released my health information to a recipient, the recipient may re-disclose my health information to third parties.

RIGHT TO REFUSE TO SIGN AUTHORIZATION

I understand that I may refuse to sign this authorization. I understand that my refusal will not affect my ability to receive treatment at the Clinic and that the Clinic may not condition treatment, payment, enrollment, or eligibility benefits on whether or not I sign the authorization.

RIGHT TO COPY OF AUTHORIZATION

I understand that I have a right to receive a signed copy of this authorization.

FEES

I understand that federal and state laws allow a fee to be charged for the copying of medical records and I will be responsible for payment of such fees.

_____ _____
Signature of Patient (or Patient's representative) Date

_____ _____
Printed Name If Representative, Basis for Authority