Docusign Envelope ID: FC6A13A6-CEFB-493E-9337-C84A1F37AF51

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

Patient's name: ________________________________ Prior Name, if any: _______________
Address: _____________________________________ Phone Number: _________________
City: _________________ State: _____________ Zip Code: __________ DOB: ______________

RECEIVING PARTY

I hereby authorize The Reproductive Medicine Group (RMG) to request 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 RMG

□ 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 TO MY PHYSICIAN VIA (SELECT ONE OPTION)

□ Physician's Office Email ____

□ Fax (please complete the fax field above)

□ Mailed to Physician's Office (please complete address field above)

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: ____

Docusign Envelope ID: FC6A13A6-CEFB-493E-9337-C84A1F37AF51

□ 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 **[Initials]** ____

□ Genetic testing information [**Initials]** ____

□ Alcohol/Drug Abuse **[Initials]** ____

□ Behavioral/Mental Health Information **[Initials]** ____

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