Pacific In Vitro Fertilization Institute
Tel 808.946.2226 Fax 808.943.1563

Thomas Kosasa, M.D.
Carl Morton, M.D.
Celia Dominguez, M.D.
Thomas T.F. Huang, Ph.D., HCLD, ELD

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS *TO* PACIFIC IN VITRO FERTILIZATION INSTITUTE

Please send medical records to: (fax) 808.943.1563 or info@pacificinvitro.com

TO: _____ Date: _____
(Physician Name)

FROM: _____ DOB: _____ MAIDEN:_____
(Print Patient Name)

I hereby authorize the use or disclosure of my individually identifiable health information as described below. I understand that this authorization is voluntary. I request copies of the following documents and actual medical reports sent to Pacific In Vitro Fertilization Institute. This information is being disclosed for the purpose of continued health care and infertility diagnosis and treatment.

- GYN Operative and pathology reports (Hysterosalpingogram, Laparoscopy, Hysteroscopy, BLT, etc.)
- Urology Reports and testing (vasectomy, vasectomy reversal, varicocele repair)
- Blood test results (FSH, LH, Prolactin, Progesterone, Estradiol)
- Fertility medication and treatment
- Semen Analysis
- Previous inseminations; IUI or IVF
- Results of any abnormal PAP (Coloscopy, Conization, LEEP, Cryosurgery or Laser Treatment)
- Current PAP results
- HIV Screening
- Other: _____

(initial)_____ I understand that if the organization to receive the information is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations.

(initial)_____ I understand Pacific In Vitro Fertilization Institute, its employees, officers and physicians are released from any legal responsibility or liability for releasing the requested information as authorized.

(initial)_____ [ ] I do <u>or</u> [ ] do not authorize the release documents with information about:

- HIV or AIDS infection or venereal disease;
- Treatment for alcohol and/or drug abuse; and/or
- Mental health or psychiatric services.

(initial)_____ I understand that this authorization will expire 12 months from the date of execution.

(initial)_____ I understand that I may revoke this authorization at any time by notifying this facility in writing. I also understand that revoking this authorization will not apply to any information released by this facility before they receive the revocation.

Print Patient Name: _____

Patient Signature: _____ Date: _____