Pacific In Vitro Fertilization Institute
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AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS *FROM* PACIFIC IN VITRO FERTILIZATION INSTITUTE

TO: Pacific In Vitro Fertilization Institute Date: _____

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. This information is being disclosed for the purpose of continued health care and infertility diagnosis and treatment. I request copies of the following documents and actual medical reports sent to:

Name: _____

Fax: _____ Phone: _____

- GYN Operative and pathology reports
- Blood test results (FSH, LH, Prolactin, Progesterone, Estradiol)
- Fertility medication and treatment
- 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 there will be a fee for a Medical Records request.
**$5.00 for up to 25 pages* **$10 for 26 pages to 100 pages* **$25 for over 101 pages*

(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: _____