



## AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

I authorize Austin Fertility Institute to  Release to:  Receive from:

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Physician or Organization Address

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Phone Fax (if applicable)

Information/copies requested from the medical records on:

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Name Date of Birth Social Security

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Date(s) of Service Send to Fax Number

**INFORMATION TO BE RELEASED:**

- |   |   |   |
|---|---|---|
| <input type="checkbox"/> All Medical History  | <input type="checkbox"/> Radiology Reports  | <input type="checkbox"/> Semen Analysis |
| <input type="checkbox"/> History and Physical | <input type="checkbox"/> Lab Work           | <input type="checkbox"/> Other _____    |
| <input type="checkbox"/> Consultations        | <input type="checkbox"/> Pathology Reports  | _____                                   |
| <input type="checkbox"/> Operative Reports    | <input type="checkbox"/> Infectious Disease | _____                                   |

This information is being released for the following purpose:

- Continued Care     Attorney/Litigation     Insurance     Disability Services  
 Other \_\_\_\_\_

I understand that I may revoke this authorization in writing at any time, except to the extent that action has been taken in reliance on it and that in any event this authorization shall expire \_\_\_\_\_ days from the date of my signature.

**If no time period is specified, it shall expire in 180 days from the date of signature.**

I understand that if the recipient authorized to receive the information is not a covered entity, e.g. insurance company or non-health care provider; the released information may no longer be protected by federal and state privacy regulations.

**TO THE PARTY RECEIVING THIS INFORMATION:** This information has been disclosed to you from records whose confidentiality may be protected by federal law. If so, federal regulations (42 CFR Part 2) prohibit you from making any further disclosure of it without specific written consent of the person to whom it pertains, or as otherwise permitted by such regulations. A general authorization for the release of information or other information is not sufficient for this purpose.

**FOR PATIENT RECORDS APPLICABLE UNDER FEDERAL LAW 42 CFR PART 2**

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Signature of Patient or Legally Authorized Representative Date

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Driver's License/ID # Relationship to Patient

*\*\*Please allow Austin Fertility Institute a minimum of 10 business days to process this request\*\**