Authorization for Release of Patient Health Information

Patient Name: _____ DOB: _____

- I understand that the information in my health record may include disclosure of information relating to communicable diseases, AIDS, HIV, alcohol, drug (substance abuse) or any such related information.
- I understand that medical records requests will be processed within 7 business days
- There are fees associated with this service; a credit card authorization is attached
- Partners need to complete a separate authorization for release of patient health information

Description of Information to be released: (*please check all that apply*):

◯ Laboratory Reports ◯ HIV/Infectious Disease Panel ◯ Radiology/Ultrasound Reports ◯ Office Visit Notes

◯ Embryonic Genetic Testing (PGD/CCS/Single Gene) ◯ with Gender information **OR** without Gender information

◯ Other (*please be specific*) _____

RECORDS RELEASED TO MD: _____ OFFICE LOCATION:_____

PHONE: _____ FAX: _____

PERSONAL REQUEST: Name: _____ DOB: _____ Last 4 of SS#: _____

Address: _____

DESCRIPTION OR PURPOSE OF THE USE AND/OR DISCLOSURE:

◯ personal records ◯ 2nd opinion ◯ consultation/referral ◯ insurance

1. I understand that I may inspect or obtain a copy of the protected health information described by this authorization
2. I understand that if the person or entity that receives the information is not a health care provider or health plan covered by federal privacy regulations, the information described previously may be re-disclosed and no longer protected by these regulations.
3. I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment or payment or my eligibility for benefits.
4. I/we also understand that I/we may revoke this authorization at any time by delivering written notification to the Privacy Officer of Advanced Reproductive Medicine, except to the extent that Advanced Reproductive Medicine has already taken action in reliance on it and that in any event this authorization expires automatically as described below.
5. If not previously revoked, this authorization will expire 12 months from the date of my signature below.

_____ _____

Signature of individual patient Date

In lieu of mailing or hand delivery, this request may be faxed to: **732-339-9400**

Please choose <u>one</u>:

◯ Summary of medical care (recent pertinent records only) ($25 fee)

◯ Complete medical record ($1 per page up to a maximum of $100.00)

Advanced Reproductive Medicine

Credit Card Authorization Form

Patient Name: _____

Name as it appears on card: _____

Billing Address:

_____

_____

Phone #: _____

Payment Information

Accepted payment Methods:

16 Digit Card Number:

_____

Expiration Date (MM/YYYY): _____

3 Digit Security Code: _____
(On the back of the card in signature box)

4 Digit Amex Security Code: _____
(Last 4 digits on front of the card above ID)

I, _____, hereby authorize the Center for Advanced Reproductive Medicine & Fertility to charge the above credit card in the amount of $ _____. I understand that by signing below I am responsible for payment of the described charges in accordance with the terms of the issuing credit card company.

Signature: _____ Date: _____
(Authorized Credit Card Holder)

Signature: _____ Date: _____
Patient