Idaho Center for Reproductive Medicine

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Authorization to Release Medical Records

Patient Name(s):_____

Date(s) of Birth:_____ Phone #(s):_____

FROM: _____

_____ Phone #_____

_____ Fax #_____

TO: _____

_____ Phone #_____

_____ Fax #_____

I hereby authorize and request the release of the following information:

_____ All Medical Records

_____ Medical record information for visit date of _____ to _____.

_____ Progress Notes

_____ **Lab reports and/or most recent pap (required at new patient visit)**

_____ Hospital and/or Operative reports

_____ Other: _____

I understand that my records may contain information regarding the diagnosis or treatment of HIV (AIDS virus), other sexually transmitted diseases, drug and/or alcohol abuse, mental illness or psychiatric treatment, and infertility treatment. I give authorization for these records to be released.

This authorization is valid for this request only. This authorization may be revoked in writing at any time with the exception of information released prior to the date of the written revocation. The Idaho Center for Reproductive Medicine cannot condition treatment or eligibility of benefits on whether the authorization is signed. Protected health information (PHI), once released, has the potential to be redisclosed by the recipient and is no longer protected by the Idaho Center for Reproductive Medicine.

Signature (patient): _____ Date: _____

Signature (partner):_____ Date:_____