The Fertility Center
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Authorization to Release Medical Information

I, _____, authorize The Fertility Center to release my records, including all medical records in your possession concerning my illness and/or treatment during the period from: _____ to: _____. My appointment is on_____ (date).

Physician: _____
Address: _____
Phone: _____
Fax: _____

Please initial next to any part of your record that you wish to be excluded in this request:

_____ Any infertility testing or treatment
_____ Embryology reports (if patient has previously undergone IVF)
_____ Any records related to pregnancy or pregnancy loss
_____ Any gynecological radiology reports
_____ Any genetic testing
_____ Any documentation of medical problems that may affect a pregnancy or an attempt to become pregnant
_____ Communicable disease infection information, as defined by statute and Michigan Department of Public Health Rules (which include venereal disease, tuberculosis, hepatitis, human immunodeficiency virus "HIV", acquired immunodeficiency syndrome "AIDS" and AIDS related complex)
_____ Alcohol and/or drug abuse treatment information protected under the regulations in 42 Code of Federal Regulations, Part 2
_____ Mental health treatment records, psychological services and social services information, including communications made by me to a social worker or psychologist.

Name_____ Date _____

Address _____

Signature _____