The Fertility Center

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REQUEST FOR RELEASE OF MEDICAL RECORDS TO A PATIENT

PATIENT NAME: _____ PHONE: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

DOB: _____ SOCIAL SECURITY NUMBER: _XXX-XX-_____

DATE RANGE OF RECORDS

REQUESTED:_____

I understand there is a possibility the information may be re-disclosed by the recipient and no longer protected under the federal privacy rules. This release is effective for 6 months from today's date.

SIGNATURE: _____ DATE: _____

RELATIONSHIP TO PATIENT: _____

WITNESS: _____

The Fertility Center does not institute a monetary charge to our patients for the dissemination of a single copy of a patient's own personal medical record for services rendered by The Fertility Center. A request of two or more copies of a patient's personal medical record for services rendered by The Fertility Center is subject to a $25.00 administrative fee.