The Fertility Center

Families Happen Here

REQUEST FOR RELEASE OF MEDICAL RECORDS

Patient Name: ____Date of Birth: ________________________

Maiden/Previous Name: _____________________________________Last 4 of SSN: XXX-XX-_____________

E-mail address: ____Phone Number: _______________________

Address: ____________________________________ City: ____________________ State: ____ Zip: _________

I authorize my records to be sent <u>FROM</u>:

Physician/Organization Name: ____

Address: ____

City:____State:_____________Zip:____________________

Phone: ____Fax: ______________________________________

I authorize my records to be sent <u>TO</u>:

☐Physician's Office ☐**<u>Self</u> -** please send by: __________ ☐Secure E-mail

☐Mail ☐Fax ☐MyChart Patient Portal

When selecting Physician's Office, please complete the information below:

Physician/Organization Name: ____

Address: ____

City:____State:_____________Zip:____________________

Phone: ____Fax: ______________________________________

INFORMATION REQUESTED: (please check **all/any** applicable boxes)

From this/these date(s) of service: ____

☐Fertility testing or treatment ☐Embryology reports ☐Billing invoices/statements

☐Radiology reports ☐Genetic Testing ☐Lab reports

☐Psychotherapy notes ☐Procedure reports ☐Office Notes

☐Pathology reports ☐Pregnancy or Pregnancy loss records

☐Communicable disease infection information as defined by statute and Michigan Department of Public Health Rules (including 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

☐Other (please describe): ____

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I understand that patient discharge instructions and records from other health care providers may be released with this routine request. I also acknowledge that The Fertility Center assumes no responsibility or liability for the accuracy or legitimacy of any records originating with a non-Fertility Center provider. There is potential that information disclosed under the authorization may be disclosed by the recipient and may no longer be protected by Federal Health Insurance Portability and Accountability Act (HIPAA). However, if information under any of the protected categories identified above is released in accordance with this authorization, any re-release of that information may not be allowed under law. This includes the Michigan Mental Health code (sections 748, 749 and 750 of the Public Act 258 of 1974 as amended) and Title 42 of the Code of Federal Regulations, Part II. In that case, the information may not be copied, shared, or re-released by the recipient, except as consistent with the stated purpose authorized in this form. This authorization may be revoked in writing at any time as outlined in the Spectrum Health Joint Notice of Privacy Practices. The Fertility Center does not require this authorization as a condition for giving treatment, payment enrollment or eligibility for benefits. This authorization will expire 6 months from the date of my signature unless I specify otherwise.

Signature: ____ **Date:** _______________________

Relationship to patient if other than self: ____

Witness: ____ **Date:** _______________________