Authorization to Release Medical Records

I, _____(patient name) hereby authorize the Center for Reproductive Immunology and Infertility to release a copy of my medical records covering the period from _____ to _____.

Please forward my records to:

Physician/Group Name: _____

Address: _____

_____

Phone Number: _____

Fax Number: _____

For the purpose of: ____ Continuing medical care; ____ Personal records; ____ Other_____

REQUESTED RECORDS:

____ Complete records ____ History and Physical ____ Consultation Reports

____ HIV Testing ____ Lab, Diagnostic test, X-ray ____ Procedures & OP reports

OTHER _____

I understand that this consent is subject to revocation at any time except to the extent that action has been taken in reliance thereof, and in any event shall expire and become null and void one hundred eighty (180) days following its signing as indicated below. I further agree that a photocopy of this authorization shall be as effective as the original thereof.

Alcohol, drug, HIV and/or AIDS information, if present, will be disclosed from records whose confidentiality is protected by Federal Law which prohibits any further disclosure without specific written authorization of the undersigned, or as otherwise permitted by such regulations.

FLORIDA STATUTES CHAPTER 64B8-10: Medical Records: 64B8-10.003 Costs of Reproducing Medical Records (in part): Any person licensed pursuant to Chapter 458, F.S. required to release copies of patient medical records may condition such release upon payment by the requesting party of the reasonable costs of reproducing the records.

Patient Signature: _____ Date:_____

Patient Name (Print):_____

Patient Date of Birth: _____

Patient Phone Number: _____

Patient Email Address: _____