

**AUTHORIZATION TO RELEASE MEDICAL INFORMATION**

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Phone number: \_\_\_\_\_ SS#: \_\_\_\_\_

**I authorize:**

Name: \_\_\_\_\_

Phone number: \_\_\_\_\_ Fax number: \_\_\_\_\_

to release medical information to:

 **John Frattarelli, M.D.** **Anatte Karmon, M.D.** **Emily Goulet, M.D.** **LeighAnn Frattarelli, M.D.** **Sloane Berger-Chen, M.D.****RECORDS AUTHORIZED TO BE RELEASED** (Note: Please see Disclosures Requiring Special Consent)

Date Range: \_\_\_\_\_ to \_\_\_\_\_

 Office/Consult Notes  Ultrasounds/Imaging Reports  Operative Reports  IVF Cycle report(s)  Ovulation  
Induction/IUI Notes  Lab Reports  Other, specify \_\_\_\_\_**This information will be used for the purpose of:** Transferring to New Physician/Continued Medical Care  Benefits Application  Disability Determination  
 Legal Representation  Personal Use  Other, specify \_\_\_\_\_**I UNDERSTAND THAT:**

- I am not required to sign this authorization and that my health care or payment for care will not be affected by my refusal.
- I am entitled to receive a copy of this authorization.
- Federal privacy regulations will no longer apply to the information disclosed.
- A copy of this authorization may be utilized with the same effectiveness as an original.

**EXPIRATION DATE:** This authorization is effective for one (1) year from the date signed below unless otherwise indicated. I understand that I can revoke this authorization at any time by contacting Advanced Reproductive Medicine, Inc. or Fertility Institute of Hawaii but that revoking this authorization will not affect disclosures made or actions taken before the revocation is received.

\_\_\_\_\_  
Patient or Representative Signature/Relationship\_\_\_\_\_  
Date**DISCLOSURES REQUIRING SPECIAL CONSENT:**

My signature below specifically authorizes the release of health information relating to testing, diagnosis, and treatment for:

 AIDS/HIV  Sexually Transmitted Diseases  Alcohol/Drug Use  Developmental Disabilities\_\_\_\_\_  
Patient or Representative Signature/Relationship\_\_\_\_\_  
Date