



ADVANCED REPRODUCTIVE
MEDICINE & GYNECOLOGY

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FERTILITY INSTITUTE
OF HAWAII

1401 S. Beretania Street Suite 250
Honolulu HI 96814
(808) 545-2800
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AUTHORIZATION TO RELEASE MEDICAL INFORMATION

Patient Name: _____ Date of Birth: _____

Phone number: _____ SS#: _____

I authorize:

Doctor's name: _____

Phone number: _____ Fax number: _____

to release medical information to:

- John Frattarelli, M.D.**
- Emily Goulet, M.D.**
- LeighAnn Frattarelli, M.D.**
- Anatte Karmon, 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/TUI 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