



**ADVANCED REPRODUCTIVE
MEDICINE & GYNECOLOGY**

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Fax-808-262-3744



**FERTILITY INSTITUTE
O F H A W A I I**

1401 S. Beretania Street Suite 250
Honolulu HI 96817
(808) 545-2800
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Patient – Partner Release of Medical Information Consent

I hereby authorize:

Advanced Reproductive Medicine and Gynecology of Hawaii, Inc.
&
Fertility Institute of Hawaii

- | | |
|---|--|
| <input checked="" type="checkbox"/> John Frattarelli, M.D. | <input checked="" type="checkbox"/> Anatte Karmon, M.D. |
| <input checked="" type="checkbox"/> LeighAnn Frattarelli, M.D. | <input checked="" type="checkbox"/> Emily Goulet, M.D. |

To release my medical records to my spouse/partner for the purpose of sharing information as it relates to my treatment plan. His/her name and contact information is as follows:

Name: _____

Address: _____

Phone Number: _____ E-mail: _____

Description of information: Disclosure is authorized for any and all medical information including physicians' notes, operative reports, laboratory results, pathology results, and radiology reports unless otherwise specified.

Duration: This authorization is valid for one year from the date of the signing unless revoked in writing by the undersigned within one year.

Patient Name: _____ Date of Birth: _____

Phone number: _____

Patient Signature

Date