

THE IVF CENTERSM

Authorization to Obtain, Release or Review Medical Information

Appointment date and time: _____

I, _____ (patient name) hereby authorize:

**The IVF Center
5901 Brick Court
Winter Park, Florida 32792
Phone: 407-672-1106
Fax: 407-678-2790**

To: Release medical record copies;

For the purpose of: _____ Continuing Medical Care

_____ Personal Records

Other _____

Records Requested:

Complete records
Consultation Reports

History and Physical
Procedures & OP reports

Lab, Diagnostic test, X-ray
Progress Notes

HIV Testing

OTHER: _____

Including Dates of Service from: _____ through _____.

Consent Acknowledgment:

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.

Please send medical records to:

Patient Signature: _____ Date: _____

Patient Name(Print): _____

Patient Date of Birth: _____

Email Address: _____

Phone #: _____