# THE IVF CENTER℠

## 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** ☐ **History and Physical** ☐ **Lab, Diagnostic test, X-ray** ☐ **HIV Testing**
**Consultation Reports** **Procedures & OP reports** **Progress Notes**

**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. A record release must be signed, and payment received before the complete chart is faxed. Depending on the record length please allow at least 5-7 business days to complete your request. Your charges are as follows:

USB Thumb drive $20.00
Email $15.00
Paper copies are $25.00 up to 50 pages 10 cents per page after.
Mailing fee $12.00

**Please send medical records to:**

_____

_____

Patient Signature: _____ Date: _____

Patient Name(Print):_____

Patient Date of Birth: _____ Phone #: _____