Texas Fertility Center

AUTHORIZATION FOR RELEASE OF CONFIDENTIAL INFORMATION (TO TFC)

PATIENT NAME:_____ DOB_____ SSN_____
Last First MI

PARTNER NAME:_____ DOB_____ SSN_____
Last First MI

ADDRESS:_____ CITY:_____ STATE:_____ ZIP:_____

DAY PHONE:_____

1. I understand that this authorization will expire 180 days after I have signed the form. I understand that I may revoke this authorization at any time by notifying the providing organization in writing, and that this revocation will be effective on the date notified except to the extent action has already been taken in reliance upon the authorization. I understand that treatment, payment, enrollment, or eligibility for benefits may not be conditioned upon me signing this authorization.
2. I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer protected by Federal privacy regulations.
3. I understand that all requests will be processed within **fifteen (15) business days** after receipt of a proper written request.
4. I understand that in compliance with Texas statute and according to rules set forth by the Texas State Board of Medical Examiners, a fee of $25.00 for the first 20 pages and $0.50 per page thereafter plus postage will be charged for record requests.
5. ❒ I do authorize ❒ I do not this information to be disclosed electronically.

I hereby authorize _____
(Name, Address, Phone#, and Fax# of Provider)

_____

to release information from my medical record as indicated below to Dr. Summer James.

INFORMATION TO BE DISCLOSED:

For Time Period: From_____to_____

- ❑ History and physical exam
- ❑ Lab reports
- ❑ X-ray reports
- ❑ Ultrasound Reports
- ❑ Summary Sheets (IVF/FSH)
- ❑ Other:_____
- ❑ Progress notes
- ❑ Pap smear
- ❑ Op/Pathology Reports
- ❑ Semen Analysis (partner must sign)

I specifically authorize the release of information relating to:

- ❑ Substance abuse (including alcohol/drug abuse)
- ❑ Mental health (including psychotherapy notes)
- ❑ Genetic Information (including, but not limited to Genetic Test Results)
- ❑ IDS/HIV related information
- ❑ Donor egg, donor sperm, donor embryo, surrogacy, or gestational carrier

X_____

PURPOSE OF DISCLOSURE: ❑ Medical Care ❑ Insurance ❑ Other:_____

Please forward this authorization to the office from which you are requesting records, so your records can be mailed or faxed to the Texas Fertility Center. Thank you.

_____ OR _____
Signature of Patient Date Parent/Legal Guardian/Authorized Person Date

_____
Signature of Partner Date

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