

Authorization to Release Medical Records to ORM Fertility

****Please fax records to 503.208.2741 or secure email to medicalrecords@ormfertility.com****

Patient Name _____ DOB ____/____/____ Phone _____
 Partner Name (if applicable) _____ DOB ____/____/____ Phone _____
 Address _____
 City _____ State _____ Zip _____

I AUTHORIZE ORM FERTILITY TO OBTAIN MY RECORDS FROM:

Provider Name _____ Clinic Name _____
 Address _____
 City _____ State _____ Zip _____
 Phone _____ Fax _____

Types of Records to be Released:

- All Records
- Only the Following Records:
 - Physician Consult Notes
 - Treatment Records
 - Embryology Reports
 - Operative Reports
 - Laboratory Reports
 - Ultrasound Reports
 - Hysterosalpinogram (HSG) Report
 - Semen Analysis/Antisperm Antibody Testing
 - Most Recent Physican and Pap
 - Other _____

Purpose of Request:

- Treatment/Consultation
- Patient Request
- Billing/Insurance
- Other: _____

Certain protected or sensitive information cannot be released without specific authorization as required by State/Federal law. I understand that this information will be disclosed if I/my partner place my/our initials in the applicable space next to the type of information.

_____ <small>Patient Partner</small> HIV/AIDS Information	_____ <small>Patient Partner</small> Drug/Alcohol Diagnosis/Treatment
_____ <small>Patient Partner</small> Genetic Testing Information	_____ <small>Patient Partner</small> Mental Health information

Duration and Right to Revoke Authorization: This authorization can be revoked at any time by submitting a notice in writing. Such revocation would be effective upon receipt. Unless revoked, this authorization is valid for both the patient and the patient's partner/spouse.

Redisclosure: I understand the information disclosed by this authorization may be subject to re-disclosure by the recipient and will no longer be protected by federal HIPPA regulations.

I understand the ORM/RML will not condition treatment, payment, enrollment or eligibility of benefits on whether I sign this authorization.

 Patient Signature

 Date

 Partner Signature (if applicable)

 Date

(OFFICE USE) Records Needed By: _____