ORM FERTILITY

Incoming Medical Records

Authorization to Release Medical Records to ORM Fertility
****Please fax records to 503.208.2741 or secrue 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.

_____ _____ HIV/AIDS Information
Patient *Partner*

_____ _____ Drug/Alcohol Diagnosis/Treatment
Patient *Partner*

_____ _____ Genetic Testing Information
Patient *Partner*

_____ _____ Mental Health information
Patient *Partner*

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 conddition treatment, payment, enrollment or eligibility of benefits on whether I sign this authorization.

_____ _____
Patient Signature *Date*

_____ _____
Partner Signature (if appliable) *Date*

(OFFICE USE) Records Needed By: _____