Center of Assisted Reproduction & Endocrinology

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Board Certified in Reproductive Endocrinology and Infertility

PLEASE SEND THIS PAGE TO YOUR REFERRING PHYSICIAN

Authorization to Obtain, Release or Review Medical Information

Appointment date and time: _____

I, _____(patient name) hereby authorize

_____(Physician or Facility) _____

_____(address, phone, fax number)

To: Release copies;

For the purpose of: ____ Continuing medical care; ____ Personal records; ____ Other_____

Including service dates: _____ through _____.

REQUESTED RECORDS:

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

OTHER _____

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.

FLORIDA STATUTES CHAPTER 64B8-10: Medical Records: 64B8-10.003 Costs of Reproducing Medical Records (in part): Any person licensed pursuant to Chapter 458, F.S. required to release copies of patient medical records may condition such release upon payment by the requesting party of the reasonable costs of reproducing the records. Reasonable costs of reproducing copies of written or typed documents or reproducing shall not be more that the following: **Total charged to patient: $20.00**

Please send medical records to:

Fertility CARE
5931 Brick Court
Winter Park, Florida 32792
Phone: 407-672-1106
Fax: 407-678-2790

Patient Signature: _____ Date:_____

Patient Name (print):_____

Patient Date of Birth: _____ SS Number:_____