FERTILITY SOLUTIONS

45 Stergis Way
Dedham, MA 02026

877-813-0159
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Fax# 781-329-2684

Authorization for Release of Medical Record Information

To request a copy of your medical record please complete this form and include the requested information. Medical records are mailed/faxed within 7 to 10 business days from the requested date. The first copy of medical records released from Fertility Solutions to another Facility/Person will be completed at no charge. *There will be a $25 charge for subsequent requests for additional copies of medical records from Fertility Solutions.*

Name: ______________________________ Date of Birth: ____________________

Address: ____

Telephone #______________________________ Alternate#____________________

Purpose of the Requested Disclosure:

Released to OB/GYN____ Second Opinion____ Changing Physicians/Practice____ Other____

I, ________________________ do hereby authorize ________________________ to release my
(Patient name) (Facility)
protected health information

To: Facility/Person(s) **(Please make sure that you provide Fax number where records can be sent to)**

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____
____
____

From: Facility/Person(s)

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____
____
____
____

Information to be released: **Please be specific and check all that applies**

Dates: __________ to __________

Clinical Notes ___ Embryology reports___ Operative Reports___

Treatment Flow sheets and summaries___ Radiology Test Reports___ Lab Test Results (not including genetics/infectious diseases) ___

I request the release of the specifically protected or privileged categories of information that *I have initialized below:*

________ HIV/AIDS and other infectious disease test results (Patient authorization required for each release request)

________Genetics test results (Patient authorization required for each release request)

Please comply with above request within 30 days as specified under HIPAA. If my request cannot be honored within 30 days, please inform me of this in writing and specify a date by which I might expect to receive records.

Patient Signature: ______________________________ Date: ____________________

September 5, 2017