##

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## AUTHORIZATION TO RELEASE HEALTH INFORMATION

PATIENT NAME:

LAST FIRST MI

DATE OF BIRTH:

PARTNER NAME:

LAST FIRST MI

DATE OF BIRTH:

**INFORMATION TO BE RELEASED FROM: INFORMATION TO BE RELEASED TO:**

Fora Fertility

NAME OF ORGANIZATION NAME OF ORGANIZATION / INDIVIDUAL

scheduling@forafertilityaustin.com

ADDRESS EMAIL

(512) 956-5006 or (866) ATX FORA

PHONE PHONE

**833 979-0493**

FAX FAX

**TYPE OF RECORDS REQUESTED:**

**FULL MEDICAL RECORD**, including all consultation notes, all laboratory and diagnostic testing including

xxx

semen analysis, HSG, MRI, operative reports, **ALL STIMULATION RECORDS, ALL EMBRYOLOGY RECORDS**

**INCLUDE SENSITIVE** information relating to sexually transmitted disease, HIV, AIDS, behavioral or mental health services and treatment for alcohol and drug abuse. (Initials are **required**: )

Other:

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. I understand that a revocation is not effective when Fora Fertility has already relied on the use or disclosure of the health information or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim. 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 HlPPA regulations. I understand that Fora Fertility will not condition treatment or payment on whether I sign this authorization. However, failure to sign an authorization may result in inability to obtain certain health care benefits, My signature below indicates that I hereby agree and authorize to release of patient health information to the above named person or organization.

Signature of Patient or Legally Responsible Party Date

Signature of Partner or Legally Responsible Party Date

**You may send this form directly to the clinic you are requesting records from OR email the completed form to** scheduling@forafertilityaustin.com **OR fax to 833-979-0943 and we will request your records on your behalf.**