REPRODUCTIVE
GYNECOLOGY & INFERTILITY
*Expertise. Compassion. Family.*

Ver 10/26/20

# RELEASE OF MEDICAL RECORDS

I hereby authorize the use or disclosure of my identifiable health information (medical records and test results, including HIV test results) as described below. I understand that if the organization authorized to receive the information is not an insurance company or healthcare provider, the released information may no longer be protected by federal privacy regulations.

Information to be Released:

**FROM:**

**Reproductive Gynecology & Infertility Care, PLLC** **Phone: (330) 375-7722**
**South Cleveland, Independence, Columbus** **Fax: (330) 253-6708**
**Akron, Canton**

**TO:**

| | |
|---|---|
| NAME/MEDICAL FACILITY: | |
| ADDRESS: | |
| CITY, STATE, ZIP CODE: | |
| TELEPHONE NUMBER: | FAX NUMBER: |

** If releasing records to self: ☐ email to:_____
**OR** ☐ mailed **OR** ☐ available for pick up ☐ Akron ☐ Columbus ☐ Cleveland ☐ Youngstown ☐ Canton

☐ Most recent labs, progress notes, and documents related to current treatment or pregnancy
☐ All available records
☐ Past 12 months or ☐ from _____ to _____

Please specifically include:_____

**Purpose of Disclosure**
❒ Medical Review ❒ Personal Use ❒ Transfer of Care ❒ Legal Review ❒ Insurance
❒ Other_____

- I release you, your physicians, and employees from liability for following this authorization and request. **I understand that it may take up to 15 business days for completion of this transaction.**
- I understand that I will ONLY be given copies of records created or ordered by this office. If you need records from other physicians, offices, or laboratories, please contact those offices for copies.
- I understand that it is the policy of this office (Reproductive Gynecology & Infertility Care) to release medical records directly to the patient. The fees charged by this office are set by the Ohio Board of Medical Examiners. The first request for medical records is at no charge. Subsequent requests will be assessed a fee.

**This authorization shall expire one year from the date below** and may be revoked at any time by written notice to the organization above.

Patient's Name: _____
First Last Date of Birth

Address: _____
Street City State Zip Code

Date: _____ Patient Signature: _____