REPRODUCTIVE GYNECOLOGY & INFERTILITY
Expertise. Compassion. Family.

Ver 10/26/20

REQUEST FOR 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:

TO:

Reproductive Endocrinology & Infertility
South Cleveland/Independence, **Phone: 330-375-7722**
Columbus, Akron, Canton **Fax: 330-253-6708**

FROM:

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

☐ 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 ❒ Transfer of Care ❒ Other_____

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: _____