Austin Fertility & Reproductive Medicine

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AUTHORIZATION FOR RELEASE OF INFORMATION

_____COMPLETE MEDICAL RECORDS
_____RECORDS OF CARE FROM _____TO _____ONLY.
_____OTHER (PLEASE SPECIFY) _____
_____PARTNER SEMEN ANALYSIS (partner MUST sign)**

HIV/AIDS: I consent to the release of any positive or negative results for AIDS or HIV infection, antibodies to AIDS or infection with any other causative agent of AIDS with the rest of my medical records. Initial_____Date_____
Initial_____Date_____ (partner)**

Reason for Release: (Article 44595b, sec. 5.08(j) Texas Revised Civil Statues requires that an authorization for release of medical records includes the "purpose of the release.")

_____Change of physician _____Moving patient
_____Application for Insurance _____Worker's Compensation/Disability
_____Consultation with another physician _____Other_____

Records Requested From:

_____
Physicians Name

_____
Address

_____
City, State and Zip

_____
Phone Number and Fax Number

Send Records To:

_____
Physicians Name

_____
Address

_____
City, State and Zip

_____
Phone Number and Fax Number

I understand that a reasonable amount of time (not to exceed 15 days) may be required to retrieve my records. If possible, please send by _____. A fee may be charged according to TMA guidelines. The fee for records is $25.00 for the first 20 pages then .50¢ per page thereafter plus postage.

I, undersigned, do hereby authorize the release of information above from my medical records. I understand that reports may include information on drug/alcohol/psychological or communicable disease treatment.

I understand that I may revoke this consent in writing at any time except to the extent that action has already been taken in reliance on it. A photocopy of this consent shall be considered valid. This authorization expires automatically in one year.

Patients Full Name (PLEASE PRINT)_____ _____

Date of Birth _____**Social Security Number** _____

Patients Signature_____**Date** _____

Witness_____**Date** _____

Partners Signature_____**Date** _____**

Witness_____**Date** _____**