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MEDICAL RECORDS RELEASE

______________________	______________________
Print Patient's Name	Print Partner's Name
______________________	______________________
Date of Birth	Date of Birth

AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION (PHI)

By signing this document, I (we) authorize Dr.______________________________

and/or the Medical Record Department of __________________________________

to provide a copy of my (our) PHI to:

Fertility Center of Maryland
110 West Road, Suite 102
Towson, MD 21204

Fax No.: 410-296-6405

Please include:
a) medical and surgical records
b) lab results
c) x-ray results
d) ultrasound results.

Exclude the
following:____.

We have an appointment ____________________ and would appreciate it if you can mail or fax them before then.

This authorization will expire in 90 days and may be revoked earlier in writing.

When my (our) PHI is used or disclosed pursuant to this authorization, it may be subject to redisclosure by the recipient and may no longer be protected by the Federal HIPAA Privacy Rule.

______________________	______________________
Signature of Patient	Signature of Partner
______________________	______________________
Date	Date

PHIrelease2015/db

Call 410-296-6400 or toll-free: 800-405-4IVF

Fax: 410-296-6405

Two locations to serve you:

110 West Road, Suite 102
Towson, MD 21204
www.fertilitycentermd.com

2014 S. Tollgate Road, Suite 107
Bel Air, MD 21015
www.fertilitycenterbelair.com