Fertility Centers OF ILLINOIS

Your Miracle. Our Mission.

AUTHORIZATION FORM FOR MEDICAL RECORDS RELEASE

Patient's Printed Name	Patient's Date of Birth	Patient's MPI Number
Spouse's/Partner's Printed Name (if applicable)	Spouse's Date of Birth	Spouse's/Partner's MPI Number

Which medical records are you requesting Fertility Centers of Illinois to release? (Please check what you are requesting):

☐ Entire medical record that is currently maintained by Fertility Centers of Illinois, including (if available) any results and/or information regarding HIV, genetics, psychotherapy/mental health, and/or substance and/or alcohol abuse.

OR

☐ Specific records: _____

_____

Who is authorized to receive the records (please be specific)?

Name: _____

Address: _____

Phone Number: _____ Fax Number: _____

What is the reason for the medical records release?

☐ Treatment with another healthcare provider

☐ For my/our own personal information/records

☐ Other (please specify): _____

What is the expiration date of this request?

☐ Until further notice

☐ Specific expiration date or event: _____

Patient Acknowledgement

- I understand I may refuse to sign this form. I am not required to sign this form to receive services at Fertility Centers of Illinois.
- I understand that I will get a copy of this form after I have signed it.
- I understand that I may revoke this authorization at any time by notifying Fertility Centers of Illinois in writing, but if I do, the revocation will not have any effect on actions Fertility Centers of Illinois has already taken in reliance on this authorization.
- I authorize Fertility Centers of Illinois to use or disclose any medical information specified in this Authorization.
- I understand that Fertility Centers of Illinois may not condition treatment, payment, enrollment or eligibility for benefits on whether I sign this authorization.
- I understand that information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal privacy regulations promulgated pursuant to the Health Insurance Portability and Accountability Act.
- State law permits healthcare providers to charge a fee for medical records, in order to compensate for staff time and equipment/supplies. Fertility Centers of Illinois charges a fee for copying records, which is waived to send records to the OB for continued pregnancy care.
- I understand that if records are to be released for both partners (if applicable), signature from both partners is required.
- I understand that it may take up to 30 days for records to be processed.

Patient's Signature: _____ Date: _____

Spouse's/Partner's signature (if applicable): _____ Date: _____

Person processing records- printed name	Signature	Date
Manager, MD, or designee reviewing records- printed name	Signature	Date