



Authorization for Use and Disclosure of Protected Health Information

PATIENT NAME \_\_\_\_\_ TELEPHONE \_\_\_\_\_

PARTNER NAME \_\_\_\_\_ TELEPHONE \_\_\_\_\_

ADDRESS \_\_\_\_\_

DATE OF BIRTH \_\_\_\_\_

I authorize release of my records from:

Center for Reproductive Medicine
2828 Chicago Ave. S., Suite 400
Minneapolis, MN 55407
Phone: 612-863-5390 Fax: 612-863-2697

- Dr. Bruce Campbell
Dr. Colleen Casey
Dr. Paul Kuneck
Dr. Dan Lebovic

Center for Reproductive Medicine
991 Sibley Memorial Hwy, Suite 100
St. Paul, MN 55118
Phone: 651-379-3110 Fax: 651-379-3111

- Dr. Mark Damario

I authorize release of my records to:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

INFORMATION TO BE RELEASED

Progress Notes Approximate Dates: \_\_\_\_\_
Lab Results Approximate Dates: \_\_\_\_\_
Operative Reports Approximate Dates: \_\_\_\_\_
Hysterosalpingogram FILM Approximate Dates: \_\_\_\_\_

Other: \_\_\_\_\_

PURPOSE OF DISCLOSURE

- Continuing Care Insurance Application Litigation
Insurance Payment Personal Other \_\_\_\_\_

ACKNOWLEDGEMENT OF UNDERSTANDING

- I understand the expiration date of this authorization is 1 year.
I understand that I may revoke this authorization at any time by notifying the providing organization in writing, and it will be effective on the date notified except to the extent action has already been taken.
I understand that Center for Reproductive Medicine cannot prevent the redisclosure of records released as a result of this request; therefore Center for Reproductive Medicine is released from any and all liability resulting from redisclosure.
I understand by authorizing this use or disclosure of information, there will be no conditions placed on my health care or payment for my health care.

Signature of patient or personal representative Relationship Date