Center for Reproductive Medicine • Advanced Reproductive Technologies
www.ivfminnesota.com

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. Colleen Casey ☐ Dr. Margaret Hopeman
☐ Dr. Dan Lebovic ☐ Dr. Joshua Kapfhamer

☐ 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: _____

_____ Genetic Testing 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