



## REQUEST/RELEASE FOR MEDICAL RECORDS

I hereby authorize the use or disclosure of my identifiable health information (medical records and test results, including HIV test results) as described below. I understand that if the organization authorized to receive the information is not an insurance company or healthcare provider, the released information may no longer be protected by federal privacy regulations.

Information to be Released:

To  From **ALL Mail and Fax Correspondence should be directed to:**

**Advanced Fertility Care, PLLC**  
**9819 North 95<sup>th</sup> Street, Suite 105**  
**Scottsdale, AZ 85258**

**Phone: (480) 874-2229**  
**Fax: (480) 874-2231**

To  From

NAME/MEDICAL FACILITY:	
ADDRESS:	
CITY, STATE, ZIP CODE:	
TELEPHONE NUMBER:	FAX NUMBER:

\*\* If releasing records to self, please indicate if you would like records  mailed **OR** to be available for  pick up at the \_\_\_\_\_ location.

All available records  Past 12 months  from \_\_\_\_\_ to \_\_\_\_\_

Please specifically include:  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**Purpose of Disclosure**

Medical Review  Personal Use  
 Transfer of Care  Legal Review  
 Insurance  Other \_\_\_\_\_

I release you, your physicians, and employees from liability for following this authorization and request. **I understand that it may take up to 15 business days for completion of this transaction.**

I understand that I will ONLY be given copies of records created or ordered by this office. If you need records from other physicians, offices, or laboratories, please contact those offices for copies.

I understand that it is the policy of this office (Advanced Fertility Care) to release medical records directly to the patient. The fees charged by this office are set by the Arizona State Board of Medical Examiners. The first request for medical records is at no charge. Subsequent requests will be assessed a fee.

**This authorization shall expire one year from the date below** and may be revoked at any time by written notice to the organization above.

Patient's Name: \_\_\_\_\_  
First Last Date of Birth

Address: \_\_\_\_\_  
Street City State Zip Code

Date: \_\_\_\_\_ Patient Signature: \_\_\_\_\_

**OFFICE USE ONLY:** Physician Approval: \_\_\_\_\_ Date: \_\_\_\_\_ / Processed by: \_\_\_\_\_ Date: \_\_\_\_\_  Faxed  Mailed  Picked Up