**ADVANCED FERTILITY CARE**

**ARIZONA ADVANCED REPRODUCTIVE LAB**

**Ver 05/18/18**

# 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 95th 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