

**RUTEK Center for Reproductive Medicine, P.A.**

**Authorization for Release of Medical Records**

**Please send a copy of this release with the requested records.**

PATIENT INFORMATION (Please print)			
Patient Name		Date of Birth	Social Security Number
Address	City		Zip Phone

**RELEASE FROM: [Name of physician or facility releasing information]**

I authorize release of my medical record from

Physician/Facility			
Address	City	Zip	Phone

**RELEASE TO: [Name of physician or facility receiving information]**

Please send my medical record to:

Physician/Facility			
Address	City	Zip	Phone

**RELEASE INFORMATION**

Reason: <input type="checkbox"/> Change of insurance	<input type="checkbox"/> Transfer of care	<input type="checkbox"/> Personal file
<input type="checkbox"/> Moving out of area	<input type="checkbox"/> Specialist consultation	<input type="checkbox"/> Legal

Please release the following (check all that apply)

RECENT H&P	LAST THREE VISITS
LAB REPORTS	X-RAY REPORTS
HOSPITAL REPORTS	OTHER:

- Please allow 15 days for processing.
- Incomplete information will delay processing.
- Use of this information for any other than the stated purpose is prohibited.
- This information is for the use of the designated recipient only and cannot be provided to any other agency.

**CONSENT**

I authorize the release of all information indicated, and I am aware that the records released may contain information relating to psychiatric or psychological testing, physical abuse, or drug and alcohol abuse.

YES NO

Initials

I authorize the release of HIV/HTLV/AIDS test results.

I understand that I may be charged for copies provided. (See reverse side.)

Signature of patient, parent, guardian, conservator, or patient representative (Please circle.)	Date
Witnessed by	Date

**Note: This consent is valid for 90 days. It may be revoked by the signer at any time.**