IVF PHOENIX®
Advanced Technologies: Making Conception Affordable

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AUTHORIZATION TO RELEASE MEDICAL RECORDS

Patient name: _____ __ Date of Birth: _____ __

Address: _____ Phone (home): _____

_____ Phone (work): _____

___ I hereby authorize the release of photocopies of the following medical records in the possession or control of **IVF Phoenix™**, its employees and/or agents. FOR THE PURPOSES HEREOF, "MEDICAL RECORDS" SHALL INCLUDE ALL CONFIDENTIAL HIV-RELATED INFORMATION (AS DEFINED IN A.R.S 36-661), CONFIDENTIAL COMUNICABLE DISEASE-RELATED INFORMATION (AS DEFINED IN A.R.S. 36-681), CONFIDENTIAL ALCOHOL OR DRUG ABUSE-RELATED INFORMATION (AS DEFINED IN 42 CFR SECTION 2.1 ET SEQ), AND CONFIDENTIAL MENTAL HEALTH DIAGNOSIS/TREATMENT INFORMATION.

_____I consent to the release of HIV/AIDS related information as part of this authorization.
Initial

Please check one:

_____All medical records

OR

_____The following described records only (specify types and dates):

_____

_____

Transfer records to (Name/Practice): _____

Address:_____Phone: _____

_____ Fax:_____

TRANSFER/RELEASE:

I have given my consent freely, voluntarily and without coercion. I may revoke this authorization at any time provided I notify **IVF Phoenix™** in writing to that effect. I understand that any release, which was made prior to my revocation in compliance with this authorization, shall not constitute a breach of my rights to confidentiality. I understand that a photocopy/fax of this authorization is considered acceptable in lieu of the original. This consent will expire sixty (60) days after the signed date below.

_____ _____
Patient's signature Date

_____ _____
Spouse/Partner's signature Date

_____ _____
Records prepared by Date

Mailed:_____Faxed:_____Received by: _____
Name Date