Fertility Centers OF ILLINOIS

Your Miracle. Our Mission.

AUTHORIZATION FORM FOR MEDICAL RECORDS RELEASE

Patient's Printed Name _____ Patient's Date of Birth _____ Patient's MPI Number _____

Spouse's/Partner's Printed Name (if applicable) _____ Spouse's Date of Birth _____ Spouse's/Partner's MPI Number _____

Which medical records are you requesting Fertility Centers of Illinois to release? (Please check what you are requesting):

☐ Entire medical record that is currently maintained by Fertility Centers of Illinois, including (if available) any results and/or information regarding HIV, genetics, psychotherapy/mental health, and/or substance and/or alcohol abuse.

OR

☐ Specific records: _____

_____

Who is authorized to receive the records (please be specific)?

Name: _____

Address: _____

Phone Number: _____ Fax Number: _____

What is the reason for the medical records release?

☐ Treatment with another healthcare provider

☐ For my/our own personal information/records

☐ Other (please specify): _____

URGENT: YES NO

(Please Indicate)

(EXPEDITED FEE MAY APPLY)

What is the expiration date of this request?

☐ Until further notice

☐ Specific expiration date or event: _____

Patient Acknowledgement

- I understand I may refuse to sign this form. I am not required to sign this form to receive services at Fertility Centers of Illinois.
- I understand that I will get a copy of this form after I have signed it.
- I understand that I may revoke this authorization at any time by notifying Fertility Centers of Illinois in writing, but if I do, the revocation will not have any effect on actions Fertility Centers of Illinois has already taken in reliance on this authorization.
- I authorize Fertility Centers of Illinois to use or disclose any medical information specified in this Authorization.
- I understand that Fertility Centers of Illinois may not condition treatment, payment, enrollment or eligibility for benefits on whether I sign this authorization.
- I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal privacy regulations promulgated pursuant to the Health Insurance Portability and Accountability Act.
- ***State law permits healthcare providers to charge a processing fee for medical records, in order to compensate for staff time and equipment/supplies. Fertility Centers of Illinois charges a fee for processing records, as well as an additional fee for expedited requests. This fee is waived if sending records to the OB for continued pregnancy care.***
- ***I understand that if records are to be released a physical signature or one verified from DOCU-SIGN from both partners (if applicable), is required.***
- ***I understand that it may take up to 30 days for records to be processed.***

Patient's Signature: _____ Date: _____

Spouse's/Partner's signature (if applicable): _____ Date: _____

Person processing records- printed name _____ Signature _____ Date _____

Manager, MD, or designee reviewing records- printed name _____ Signature _____ Date _____