

Patient Name: _____ **Date of Birth:** _____

Address: _____
_____ **Telephone:** _____

Information to be **Released From:** _____ Information to be **Released To:** _____

Doctor/Clinic Name: _____ Name: _____

Address: _____ Address: _____

Phone Number: _____ Phone Number: _____

Information to be released (MUST CHECK ALL THAT APPLY):

- History & Physical Ultrasound Reports Surgery/Pathology Reports Endometrial Biopsy
- Progress Notes Radiology/HSG Reports Semen Analysis Billing Information
- Lab Reports Flowsheets (Cycle/IUI/Etc) Other _____

All records pertaining to psychiatric/mental health, chemical dependency and/or AIDS/HIV related illness/testing will be released unless otherwise indicated by a checkmark here: _____

Please indicate any restrictions. (Specify) _____

For the following date(s) of treatment or condition: _____
(Specify dates of treatment or condition)

I am requesting this information be released for the following purpose:

- Continued care Insurance Legal Personal use Other _____

Information will be mailed unless otherwise stated here: _____

- I understand I may revoke this authorization by written request at any time to the address listed at the top of this form. I understand that the revocation will not apply to information that has already been released in response to this authorization.
- This authorization will automatically expire one year from the date of my signature, or a lesser period of time as specified here: _____. The expiration period noted here may exceed one year only in certain situations as specified by law.
- I understand that once information is released pursuant to this authorization, UMPHysicians cannot prevent the redisclosure of the information to another third party.
- I understand this authorization must be filled out completely and signed in order to be considered valid.
- A copy of this authorization is as valid as the original bearing my signature.
- Except for research-related treatment, UMPHysicians will not condition treatment on my signing this authorization.
- I understand there may be a charge associated with the Release of Information Services rendered. There is no charge for release of information to other health care facilities.

Signature of Patient / Legal Representative
(If legal representative is signing, please also print name)

Legal Representative's authority to sign
(parent, guardian, health care power of attorney, etc.)

Date

REASON PATIENT IS UNABLE TO SIGN: Minor Deceased Other: _____