IVF MICHIGAN ROCHESTER HILLS & FLINT

2 Hurley Plaza, Ste 209, Flint, MI 48503
Phone: 810-262-9714 ; Fax: 810-262-7040

3950 S Rochester Rd, Ste 2300, Rochester Hills, MI 48307
Phone: 248-844-8845 ; Fax: 248-844-9852

IVF Michigan Rochester Hills and Flint
Records Release Policy

A signed medical records release is required to release any medical information. Once the signed release is received the records will be provided within 10 business days. There is a minimum administration fee of $25 per records request. This fee will cover up to 50 pages, anything over 50 pages will be charged at $.50 per page. This fee must be paid in full prior to receiving the records. If your chart is being stored off site, an additional fee of $15 will apply to have the chart returned to the office and processed. Please retain this copy for your personal file. Please note that for the purpose of continuation of care copies will be provided directly to your physicians, upon the proper release, at no charge.

If you have any questions or concerns, please contact the office.

My signature below indicates I have been informed of the above policy pertaining to the release of my records.

_____ _____

Signature Date

For Office Use Only:

Date records were released:_____

IVF MICHIGAN ROCHESTER HILLS & FLINT, P.C.

PATIENTS AUTHOROZATION FOR DISCLOSURE OF HEALTH RECORDS

****PLEASE SIGN AND FORWARD TO YOUR PHYSICIAN PRIOR TO YOUR FIRST OFFICE VISIT IN ORDER TO HAVE PREVIOUS MEDICAL RECORDS FORWARDED TO OUR OFFICE****

_____ _____ _____

(PRINT FULL NAME OF PATIENT) (DATE OF BIRTH) (SOCIAL SECURITY #)

RELEASE FROM:

IVF MICHIGAN ROCHESTER HILLS & FLINT, PC

2 Hurley Plaza, Ste 209, Flint, MI 48503

Phone: 810-262-9714 Fax: 810-262-7040

3950 S Rochester Rd, Ste 2300,
Rochester Hills, MI 48307

Phone: 248-844-8845 Fax: 248-844-9852

RELEASE TO: _____

SPECIFIC INFORMATION TO BE DISCLOSED:

- ☐ IVF and/or IUI treatment
- ☐ Gynecological Surgeries
- ☐ Hysterosalpingogram films
- ☐ Pregnancy Records
- ☐ All Records
- ☐ Other _____

PURPOSE FOR DISCLOSURE:

- ☐ Moving out of area
- ☐ Transfer of ALL care
- ☐ Pregnant and discharged to OB
- ☐ Personal
- ☐ Second Opinion
- ☐ Other _____

I understand that my records (including alcohol, drug abuse, mental status and serious infectious and communicable diseases including venereal diseases, tuberculosis, HIV, AIDS, and ARC) are protected under the State and Federal Confidentiality Regulations and cannot be disclosed without my written consent unless provided for in the regulations.

I understand that I may revoke this authorization at any time and that this authorization pertains to fulfillment of the above stated purpose(s) and will automatically expire after six months from date of signature.
I have read the above, and acknowledge that I am familiar with and fully understand the terms and conditions of this authorization.

I DO HEREBY CONSENT TO THE DISCLOSURE OF THE ABOVE DESCRIBED INFORMATION CONTATINED IN MY HEALTH RECORD.

_____ _____

DATE PATIENT'S (GUARDIAN'S) SIGNATURE

Prohibition of redisclosure: This information has been disclosed to you from records whose confidentiality is protected by Federal and State Law. Federal regulations (423 CFR Part 2) prohibit you from making any further disclosure of this information except with the specific written consent of the person to whom it pertains. A general authorization for the release of medical or other information if held by another party is not sufficient for this purpose. Drug abuse office and treatment act of 1972 (21 USC 1175) comprehensive alcohol abuse, alcoholism prevention, treatment and rehabilitation act of 1970 (42USC 4582), federal register, Vol. 40 No. 127, Tuesday, July 1, 1975.