PATIENT'S AUTHORIZATION FOR DISCLOSURE OF HEALTH RECORDS

****PLEASE SIGN AND FORWARD TO YOUR PHYSICIAN YOU ARE REQUESTING RECORDS FROM****

DO NOT SEND THIS RELEASE BACK TO OUR OFFICE

YOU MAY WANT TO CALL OUR OFFICE PRIOR TO YOUR APPOINTMENT TO CONFIRM RECORDS WERE RECEIVED

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

RELEASE TO:

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

PATIENT HAS AN APPOINTMENT ON: _____

RELEASE FROM: _____

SPECIFIC INFORMATION TO BE DISCLOSED (include dates of treatment):

- ☐ IVF and/or IUI treatment
- ☐ Gynecological Surgeries
- ☐ Hysterosalpingogram **films**
- ☐ Hormone blood work
- ☐ Most recent pap
- ☐ Other _____

PURPOSE AND NEED FOR DISCLOSURE: Patient seeing Dr. Mostafa Abuzeid, M.D. – Reproductive Endocrinology and Infertility (REI)

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 CONTAINED IN MY HEALTH RECORD.

_____	_____
DATE	PATIENT'S (GUARDIAN'S) SIGNATURE