Rocky Mountain Fertility Center
Rocky Mountain Fertility Lab
12770 Lynnfield Drive
Englewood, CO 80112

Dr. Deborah Smith
303-999-3877

Authorization for the Disclosure of Protected Health Information

(Use this form to get your medical records sent to another physician from our office)

As required by the Health Insurance Portability and Accountability Act of 1996 Rocky Mountain Fertility Center and Rocky Mountain Fertility Lab may not use or disclose your health information without your authorization. Your signature on this form indicates you are giving permission for the uses and disclosures below. Please complete this form and fax to 303-999-3878. We will then call you to collect the fee for copying and sending the records.

Patient Name: **DOB:** **Phone #:**

I authorize:

Rocky Mountain Fertility Center
12770 Lynnfield Drive
Englewood, CO 80112

Fax : 303-999-3878
Phone: 303-999-3877

To release all medical records including old records received from prior providers, laboratory results, and radiology reports to the facility listed below. If these records contain any "sensitive" information from the releasing practice or in old records from previous providers about HIV/ AIDS status, behavioral health, cancer diagnosis, drug/ alcohol abuse, or sexually transmitted diseases, I give my consent to the release of this information with the records. ☐ ***check this box if you restrict the release of the "sensitive" information.***

Please send the medical records to:

Name:

Address:

Phone number:

Fax number:

Email Address:

I hereby give permission to the releasing facility to disclose my individually identifiable health information (medical records/ billing/ insurance claims) for the uses listed below. I understand once this information is disclosed it may no longer be protected. I understand my authorization is voluntary, that further treatment cannot be conditioned upon my signing this authorization and there may be a cost associated with copying medical records. I understand that after the custodian of the records discloses my health information, it may no longer be protected by the federal privacy (HIPAA) laws, I understand my authorization is voluntary and I may refuse to sign this authorization. My refusal to sign will not affect my ability to obtain treatment, receive payment or eligibility for benefits unless allowed by law, This authorization expires in 1 year. A copy of this form or a facsimile of this form is considered as valid as the original. Any medical records received/sent by mail, email, or fax will be sent unencrypted and RMFC cannot guarantee the security of the email, mail or fax from computer hackers, phone companies, analog phone lines, thieves etc RMFC cannot be responsible for breaches in security of your PHI sent by fax, mail or email. This authorization includes the release of information created after the date of signature on the bottom of this form until the release of records expires. This authorization may be revoked in writing at any time, by sending a letter to the releasing facility.

Information to be used for:

☒ Continuity of care
☐ Claim Information
☐ School
☐ Personal uses
☐ Legal
☐ Worker's Compensation
☐ Other _____

_____ _____
Signature Date

I understand I have the right to revoke my request to release my medical information by signing the below statement.

Only sign here if you wish to I revoke this authorization. _____ (signature and date)