Rocky Mountain Fertility Center
Rocky Mountain Fertility Lab

Dr. Deborah Smith

Authorization for the Disclosure of Protected Health Information

(Use this form to get your medical records from another physician sent to 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 **send your request** to the office you wish to obtain medical records from. Some programs require both a release from the female partner & male partner for IVF records. Additionally a separate release for the IVF lab may be needed.

Patient Name:_____DOB:_____

I hereby authorize (Obtain information from-Releasing facility):

Name :_____

Address:_____

Phone number:_____

Fax number:_____

Please release all medical records <u>including old records received from prior providers</u>, 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.

Release information to (Receiving Facility):

Rocky Mountain Fertility Center at Meridian
12770 Lynnfield Drive
Englewood, Colorado 80112

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

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 by mail, email, or fax will be sent unencrypted to RMFC and RMFC cannot guarantee the security of the email, mail or fax from computer hackers, phone companies, analog phone lines, thieves etc until it arrives at our office, and 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 and the release of records can include records created within 1 year after the signature date. 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)