Audubon
FERTILITY

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

I authorize Audubon Fertility to ☐ Release to: ☐ Receive from:

_____

Physician/Organization/Self Address

_____

Phone Fax (if applicable)

Information/copies requested from the medical records on:

_____

Name Date of Birth Social Security

If mailing medical records, please mail to:
Audubon Fertility
Attention: Medical Records
4321 Magnolia St
New Orleans, LA 70115

INFORMATION TO BE RELEASED:

☐ All Medical History ☐ Radiology Reports ☐ Semen Analysis
☐ History and Physical ☐ Lab Work ☐ Other _____
☐ Consultations ☐ Pathology Reports ☐ Dates of Service: _____
☐ Operative Reports ☐ Infectious Disease _____

(Genetic test, HIV/AIDS, and Psychotherapy results requires a separate "sensitive diagnosis release form" please request this form if you are in need of these records)

This information is being released for the following purpose:

☐ Continued Care ☐ Attorney/Litigation ☐ Insurance ☐ Disability Services
☐ Other _____

I understand that I may revoke this authorization in writing at any time, except to the extent that action has been taken in reliance on it and that in any event this authorization shall expire ____ days from the date of my signature.
If no time period is specified, it shall expire in 90 days from the date of signature.
I understand that if the recipient authorized to receive the information is not a covered entity, e.g. insurance company or non-health care provider; the released information may no longer be protected by federal and state privacy regulations.
TO THE PARTY RECEIVING THIS INFORMATION: This information has been disclosed to you from records whose confidentiality may be protected by federal law. If so, federal regulations (42 CFR Part 2) prohibit you from making any further disclosure of it without specific written consent of the person to whom it pertains, or as otherwise permitted by such regulations. A general authorization for the release of information or other information is not sufficient for this purpose.
FOR PATIENT RECOREDS APPLICABLE UNDER FEDERAL LAW 42 CFR PART 2

_____ _____
Signature of Patient or Legally Authorized Representative Date

_____ _____
Driver's License/ID # Relationship to Patient

Please allow Audubon Fertility a minimum of 10 business days to process this request*