Midwest Reproductive Center

Gather Your Medical History
Authorization to Release Protected Health Information

Patient Name: _____ Date of Birth: _____ SSN _____

Address: _____

City: _____ State:_____ Zip: _____

To be completed by requestor: ____Pick up ____ Mail ____ Fax ___ Other _____
If needed for a doctor's appointment, please specify date of appointment: _____

Reason for requesting information: _____
(May be subject to copying fee)

The following individual or organization is authorized to make the following disclosure:
Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____

The type and amount of information to be disclosed:

_____ my entire medical records (including HIV/AIDS testing)
_____ please exclude the following. _____
__X__ latest Pap smear
__X__ latest Mammogram
__X__ any gynecology operative reports or procedures
__X__ fertility therapy
__X__ any diagnostic tests pertaining to infertility
__X__ any lab work performed in the last 18 months
__X__ semen analysis

This information may be disclosed and used by the following individual or organization:
Midwest Reproductive Center
20375 W 151st Street, Suite 403
Olathe, Kansas 66061
Phone: 913-780-4300 Fax: 913 780-4250

I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing. I understand that the revocation will not apply to information already released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire on the following date, event or condition (not to exceed one year): _____.
If I fail to specify an expiration date, event or condition, this authorization will expire 90 days from the date signed.

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand that I may inspect or obtain a copy of the information to be issued or disclosed as provided in CFR 164.524. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by Federal confidentiality rules. If I have question about disclosure of my health information, I can contact the authorized individual or organization making disclosure.

I understand the information in my health record may include psychiatric, alcohol or drug abuse/testing information, which may be protected by Federal and State Regulations. I also understand that my health record may include information relating to AIDS/ HIV, and/ or sexually transmitted disease.

Patient Signature: _____ Date _____
Authorized Representative/ Parent _____ Date _____
Printed name of Authorized Representative/ Parent _____
Relationship to Patient: _____
Address and Phone No. of Authorized Representative/Parent: _____