

## Midwest Fertility Specialists

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### Request for an Individual's Health Information

**Last:** \_\_\_\_\_ **First:** \_\_\_\_\_ **Middle:** \_\_\_\_\_

**Other Name Used:** \_\_\_\_\_ **Date of Birth:** \_\_\_\_\_ **SS#:** \_\_\_\_\_

**Address:** \_\_\_\_\_

**Home Phone:** (     ) \_\_\_\_\_ **Work Phone:** (     ) \_\_\_\_\_

I hereby request access to the protected health information in my health record from (date) \_\_\_\_\_ to (date) \_\_\_\_\_

Most recent Progress Note

Pathology/Lab Reports

U/S Reports

Billing Records

Entire Health Record

Other \_\_\_\_\_

I will pick up the copies of my records

Mail copies of my records to the individual noted below :

Records From:	Records To:
Name: _____	Name: _____
Address: _____	Address: _____
Phone: _____	Phone: _____
Fax: _____	Fax: _____

Purpose of Request: \_\_patient's request, \_\_dispute, \_\_referral, \_\_other: \_\_\_\_\_

**I understand:**

- I may revoke this authorization at any time by providing my written revocation to **Midwest Fertility Specialists**. My revocation will not apply to information already retained, used or disclosed in response to this authorization. Unless revoked, the automatic expiration date will be six (6) months from the date of signature.

Signature of patient or legal representative

Date

- HIV and AIDS Information Authorization: Specific authorization is required for HIV-related information. Please sign below to release this information

Signature of patient or legal representative

Date