



# Seattle Reproductive Medicine<sup>®</sup>

A N I N T E G R A M E D<sup>®</sup> A F F I L I A T E

## AUTHORIZATION TO RELEASE MEDICAL INFORMATION

**I hereby authorize the use or disclosure of my individually identifiable health information has described below.** I understand that this authorization is voluntary. I understand that if the organization authorized to receive the information is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations.

**Each patient must submit a separate request for medical records; release forms may not be shared.**

**Please allow 5 business days for processing copies of your medical records.**

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Last Name: \_\_\_\_\_ First name: \_\_\_\_\_ MI: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Medical Record Number: \_\_\_\_\_

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To/Organization receiving the information (you must provide an address or fax number):

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Fax number: \_\_\_\_\_

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### Information to be disclosed:

#### Medical Records

- Stimulation Grid (cycle stimulation details)
- Progress Notes (clinic/chart notes)
- OB Ultrasounds reports (pregnancy ultrasounds)
- Daily Ultrasounds reports (follicular dynamic/ovarian ultrasounds)
- Lab Results
  - Include sensitive information relating to sexually transmitted disease, HIV, AIDS, behavioral or mental health services and treatment for alcohol and drug abuse
  - Do not** include sensitive information relating to sexually transmitted disease, HIV, AIDS, behavioral or mental health services and treatment for alcohol and drug abuse
- Semen Analysis
- Embryology Documents
- Operative reports (Surgery/Hysterosalpingogram/Hysteroscopy/Sonohysterogram)

Please mail back to:

Seattle Reproductive Medicine  
1505 Westlake Ave N, Suite 400  
Seattle, Washington 98109  
Attention: Medical Records

-or-

Fax to:

(206)285-4555  
Attention: Medical Records

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This authorization will be expired one (1) year after the date it was authorized unless specified.

This authorization will expire on \_\_\_\_/\_\_\_\_/\_\_\_\_ or after \_\_\_\_\_ days

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\_\_\_\_\_  
Signature of Patient or Personal Representative

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed Name of Patient or Personal Representative

\_\_\_\_\_  
Description of Personal Representative's Authority