

## Authorization to Release Medical Information

I hereby authorize the use or disclosure of my individually identifiable health information as 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.

Patient Name/Last: \_\_\_\_\_ First: \_\_\_\_\_ MI: \_\_\_\_\_

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

To: \_\_\_\_\_ From: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

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

Please note: If the above information is not provided, we will not be able to complete your request.

Location

Please indicate which office(s) you have been seen:

- Seattle                       Bellevue                       Tacoma
- Kirkland-previously Northwest Center for Reproductive Sciences

If you were a patient of Northwest Center for Reproductive Sciences (NCRS) and you would like to obtain copies of your records, please sign below.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

Information to be disclosed:

Medical Records

- Stimulation Grid (cycle stimulation details)
- Progress Notes (clinic/chart notes)
- OB ultrasound reports (pregnancy ultrasounds)
- Daily ultrasound reports (follicular dynamics/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/Hysterosalingogram/Hysteroscopy/Sonohysterogram)

Please mail back to:

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

-OR-

Fax to:

(206)285-4555  
Attention: Medical Records

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

\_\_\_\_\_  
Date

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

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