1505 Westlake Ave N. Suite 400 Seattle WA 98109 ● Fax: 206-301-5679 ● Phone: 206-301-5000x5349

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 and may be revoked at any time. 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 (i.e., HIPAA).

Release forms may not be shared. A new form MUST be completed for every request.

** Please allow 15 business days for processing requests for medical records **

Patient Name/Last:________________________________ First: ___________________________ MI: _____

Date of Birth: _________________________________ Medical Record Number: ____________________

Records to be sent FROM:

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Fax number: ____________________________

Records to be sent TO:

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Fax number: ____________________________

E-mail: _________________________________

☐ **SRM Patient Portal**

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

Information to be disclosed:

☐ **For Graduating OB Patients**: Please check this box to release relevant pregnancy records (Progress notes, OB Ultrasounds, and *HIPAA Sensitive* lab results) to your designated Obstetrician's office. *Please proceed to signature*

☐ Stimulation Grid (cycle stimulation details)

☐ Progress Notes (clinic/chart notes)

☐ OB ultrasound reports (pregnancy ultrasounds)

☐ Daily ultrasound reports (follicular dynamics/ovarian ultrasounds)

☐ Lab Results (**Please check here AND appropriate box below)**

- ☐ Include sensitive information relating to sexually transmitted disease, HIV, AIDS, genetic testing, behavioral or mental health services and treatment for alcohol and drug abuse
- ☐ DO NOT include sensitive information relating to sexually transmitted disease, HIV, AIDS, genetic testing, behavioral or mental health services and treatment for alcohol and drug abuse

☐ Semen Analysis

☐ Embryology Documents

☐ Operative Reports (surgery/hysterosalingogram/hysteroscopy/sonohysterogram)

____ _________________________

Signature of Patient or Personal Representative — Date

____ _________________________

Printed Name of Patient or Personal Representative — Description of Personal Representative Authority