



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.**

\*\* Medical records are now processed through Ciox. They may require that you create a password through their portal system. 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:**

**Records to be sent TO:**

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

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

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

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

E-mail: \_\_\_\_\_

**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