Reproductive Science Center
Experience Never Mattered More
89 Davis Rd, Suite 280 Orinda, CA 94563 Tel: (925) 867-1800 Fax: (925) 254-7810

AUTHORIZATION FOR THE RELEASE OF MEDICAL RECORDS

TO OTHER PROVIDER, FACILITY OR PERSON

Request to transfer medical records from the Reproductive Science Center of the San Francisco Bay Area to another location for the purpose of medical treatment.

Please type or print legibly in blue or black ink.

Requesting Patient's Name:_____

Patient's Address:_____
(Include apartment or unit number)

_____
City State Zip

Date of Birth _____ Social Security No.:_____

Specify Record Type:
___Medical Information
___Drug/Alcohol Information
___Other Health Information (specify below)
___Semen Analysis**** must be signed by male partner on this form***
____Psychiatric Information
____Results of HIV Blood Test
____Genetic Testing

Specify the records to be disclosed: _____
_____

Reason for transfer of records _____

Revocation: This authorization is also subject to written revocation by the undersigned at any time between now and the disclosure of information by the disclosing party. My written revocation will be effective upon receipt, but will not be effective to the extent that the requester or others have acted in reliance upon this authorization.
Redisclosure: I understand that the requester may not lawfully further use or disclose the health information obtained from another health care provider unless another authorization is obtained from me or unless such use or disclosure is specifically required or permitted by law. If this information is disclosed it may not be complete.
Duration: This authorization shall be valid for 90 days of my signature below. A copy of this authorization form shall be deemed as valid as the original.

Please process this request within 15 days, as provided by law.

I hereby authorize you to furnish my medical information to the medical facility or person indicated below.

To: _____
(Name of Physician, medical group or clinic, person)

Street Address_____

City, State, ZIP _____

Patient's Signature:_____ Date:_____

Partner's Signature:_____ Date:_____

A Copy of this form has been provided to me by the Reproductive Science Center of the San Francisco Bay Area