BOSTON IVF
THE ARIZONA CENTER

Authorization to Release Medical Records

Patient Name: _____ Account #: _____

Address: _____ Date of Birth: _____

_____ Phone (Day): _____

Social Security #: _____ Phone (Home): _____

I hereby authorize _____
to send / release photocopies of medical records concerning the above named patient to:

- ☐ Rita Sneeringer, MD, FACOG, *Medical Director*
- ☐ Linda Nelson, MD. PhD, FACOG
- ☐ Rekha Matken, RNC, MS, WHNP-BC, *Clinical Director*

Boston IVF – The Arizona Center
8901 E. Mountain View Road, Suite 201
Scottsdale, AZ 85258
480-559-0252
FAX: 480-661-4141

For the purpose of: _____

MEDICAL RECORDS

I authorize the release of the photocopies of the following medical records and/or x-ray films in the possession or control of the above named party acknowledged to release requested records, it's employees and/or agents. [For purposes hereof, "Medical Records" shall include all confidential HIV related information (as defined in A.R.S. Section 36-661), confidential communicable disease related information (as defined in 42 CFR, Section 2.1 et seg), and confidential mental health diagnosis / treatment information..]

(CHECK ONE)

- ☐ All medical records of the past two (2) years of treatment (or)
- ☐ The following described records ONLY (specify type and dates): _____

_____

This consent will expire sixty (60) days after the signed date below. I have given my consent freely, voluntarily and without coercion. I may revoke this authorization at any time providing I notify the above named physician in writing to that effect. I understand that any release which has been made prior to my revocation in compliance with this authorization shall not constitute a breach of my rights to confidentiality. I understand that a photocopy of this authorization is considered acceptable in lieu of the original.

_____ _____
Patient Signature Date

_____ _____
Records prepared and transmitted by Date