



Authorization for Release of Medical Records

The Health Insurance Portability and Accountability Act (HIPAA), passed by the U.S. Congress in 1996, has very specific requirements and rules regarding confidentiality and access for patient medical records. Fertility Physicians of Northern California (FPNC) is committed to uphold and protect the confidentiality of your medical records.

Requesting Records from Other Providers

You may use the attached form to request records from each physician you have seen regarding fertility or reproductive concerns. **The form should be sent directly to the other physician (not to FPNC).** Your request(s) should be made as early as possible in your treatment, preferably in advance of your New Patient Consult appointment with FPNC. Records pertaining to your prior reproductive care (OB/GYN, lab results, physical examinations, etc.) will assist our physicians in understanding your treatment history.

You may choose to have your records released to you, or sent directly to FPNC. Past providers may take up to two weeks to release your records, so plan accordingly. There may be charges associated with the copying of your records.

Requesting Records from FPNC

To request records from FPNC, please use this same form and indicate to whom you wish the records released. You may submit your form in person, by mail or fax to (408) 355-1754. Record releases are done as quickly as possible on a first come, first served basis, with a legal maximum of 15 days for processing.

FPNC does not charge patients for copying records within our normal time frame. Rush jobs (less than ten working days) will be charged a \$20.00 expediting fee.

Other Information

If you require a Release of Records for your partner, that person will also need to sign this form or submit one individually. We cannot release partners' records to each other without prior authorization.

Records may only be released to the person requesting them, another physician or your authorized representative.

Records may be picked up personally in either of our offices, or mailed. We do not fax medical records. Please provide any third party who might pick up records on your behalf with a written note authorizing their receipt of your records

Thank you for your understanding of our efforts to maintain the highest possible standards of patient care and confidentiality.

**FERTILITY PHYSICIANS OF NORTHERN CALIFORNIA
AUTHORIZATION FOR RELEASE OF RECORDS**

Records Subject:

Patient Name: _____

Date of Birth: _____

Partner Name: _____
(IF REQUESTING RECORDS USING THIS FORM)

Date of Birth: _____

Authorization for use/disclosure of information:

I voluntarily authorize and direct the health care provider named below to disclose my health information during the term of this Authorization to the recipient that I have identified below.

Health Care Provider:

From: _____ Fertility Physicians of Northern California

OTHER HEALTH CARE PROVIDER NAME

OTHER HEALTH CARE PROVIDER ADDRESS

OTHER HEALTH CARE PROVIDER CITY/STATE/ZIP

Record Recipient:

To: _____ Fertility Physicians of Northern California
_____ Fax 408-355-1754

RECIPIENT NAME (MAY BE PATIENT OR PROVIDER)

RECIPIENT ADDRESS

RECIPIENT CITY/STATE/ZIP

Purpose:

I understand that the specific purpose of this Authorization is:

Information to be disclosed:

This authorization permits the above named health care provider to disclose the following medical records:

Release Records **Do NOT Release Records**

- All of my health information that the provider has in his or her possession, including information relating to any medical history, mental or physical condition and any treatment received by me, including without limitation, x-rays, genetic testing, psychotherapy notes and other mental health information, drug, alcohol or other controlled substance information, billing information, correspondence, and records from other health care providers that the above-named health care provider may hold.
- All of my health information described above EXCEPT for the following: _____

- Only the following records or types of health information (insert dates of treatment, types of treatment or other designation): _____

- All HIV test results or any related AIDS virus information.
INITIAL HERE _____

Term:

This Authorization will remain in effect for one (1) year from the date this authorization is signed.

Redisclosure:

I understand that once my health care provider discloses my health information to the recipient identified above, my health care provider cannot guarantee that the recipient will not re-disclose my health information to a third party. The third party may not be required to abide by this Authorization or applicable federal and state law governing the use and disclosure of my health information.

Refusal to sign/right to revoke:

I understand that I may refuse to sign or may revoke (at any time) this Authorization for any reason and that such refusal or revocation will not affect the commencement, continuation or quality of my treatment by my health care provider.

Revocation:

I understand that the Authorization will remain in effect until the term of this Authorization expires or I provide a written notice of revocation to my health care provider at my health care provider’s regular office address. The revocation will be effective immediately upon my health care provider’s receipt of my written notice, except that the revocation will not have any effect on any action taken by my health care provider in reliance on this Authorization before it received my written notice of revocation.

Questions:

I may contact my health care provider for answers to my questions about the privacy of my health information at my health care provider’s regular office telephone number. I understand that I have right to receive a copy of this authorization from my health care provider.

Photocopy:

A photocopy, fax or electronic copy of this authorization shall be considered as effective and as valid as the original.

PATIENT’S SIGNATURE OR REPRESENTATIVE

DATE

PARTNER’S SIGNATURE
(authorizing release of Partner’s records)

DATE