MISSOURI FERTILITY.COM
When family matters, we're here for you.
1506 E Broadway, Suite 220, Columbia, MO 65201
Phone: (573) 443-4511 Fax: (573) 443-7860

AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

This release expires 90 days from the date or upon written notification

Patient's Name: _____

Date of Birth: _____ SSN: _____

Previous name under which records may be filed: _____

Patient's Phone Number: _____

Purpose(s) of the information to be released: _____

I, the undersigned authorize and request **Missouri Fertility** to:

_____Release Information to: _____Obtain Information from:

Name: _____

Phone: _____ Fax:_____

Address: _____

City: _____ State:_____ Zip: _____

Please initial the appropriate box indicating the records to be released. If no box is initialed, records to be sent are those generated in office only.

_____ The records generated in the office only, not including x-rays and lab reports.

_____ The entire medical record, including x-rays and lab reports.

_____ X-rays and lab reports only.

_____ Other: _____
(Specific date of treatment and/or specific parts of records)

Re-disclosure: I understand that once information is release to the above names person or persons, my information may be subject to re-disclosure by the recipient and may no longer be protected Personal Health Information (PHI). Drug and/or Alcohol Abuse, and/or Psychiatric, and/or HIV/AIDS Records Release: I understand that my medical or billing record may contain information in reference to drug and/or alcohol abuse, psychiatric care, sexually transmitted disease, Hepatitis B or C testing, HIV/AIDS testing and/or treatment, and/or other sensitive information. I agree to this release.

Signature of patient legal representative: _____ Date:_____

Relationship to patient if legal representative:_____

Identity of Requester verified via: _____ Photo ID _____Matching Signature

Other, Specify_____ Verified by: _____