Red Rock Fertility Center
9120 W. Russell Road, Suite 200
Las Vegas, NV 89148
Ph: 702-262-0079 * Fax: 702-685-6910

Red Rock Fertility®

Authorization for Release of Protected Health Information

I am scheduled at Red Rock Fertility Center on _____, and the office has requested that medical records be forwarded to the office prior to my scheduled appointment.
I hereby authorize:

Provider/Facility Name:_____

Address: _____ City: _____State: _____ Zip: _____

Phone: _____ Fax: _____

Patient (print name):_____ DOB: _____

Partner's (print name):_____ DOB: _____

Female Patient Records Requested:

- ☐ All Records
- ☐ Chart Notes
- ☐ Lab Results
- ☐ History & Physical
- ☐ X-Rays/US Reports
- ☐ Operative Reports

Male Patient Records Requested:

- ☐ Semen Analysis
- ☐ Lab Results
- ☐ All Records

To release a copy of the following information, <u>records should be within the last 12 months</u>

Medical records may include confidential information related to communicable disease, alcohol or drug abuse, genetic information, blood, breath, or urine screen, and mental health diagnosis and treatment.

☐ I DO / ☐ DO NOT authorize the release of this type of information.

I understand:

- I may revoke this authorization except to the extent that it has already been acted upon.
- Treatment will not be conditioned on my providing this authorization unless the provision of health care is solely for the purpose of creating protected health information for disclose to third party.
- Once this information is released it may be re-disclosed by the recipient and may no longer be protected information.
- I may have a signed copy of this authorization.

Patient's Signature: _____ Date: _____

Partner's Signature: _____ Date: _____

Note: This release will expire 1 year after the signed date.