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, _____, authorize Red Rock Fertility Center to release my medical records to:
(Print Name)

Provider/Facility Name: _____

Address: _____ **City:** _____**State:** _____ **Zip:** _____

Phone: _____ **Fax:** _____

Patient (print name):_____ **DOB:** _____

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

Date of doctor's appointment (if applicable): _____

Reason for release: _____

Please release the following records:

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

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: _____

Please note, it may take 5-10 business days to process records requests. If you are requesting records for personal use, there is a charge of $0.60 per page plus postage.
Note: This release will expire 1 year after the signed date.