Center for Reproductive Medicine • Advanced Reproductive Technologies
www.ivfminnesota.com

Authorization for Use and Disclosure of Protected Health Information

PATIENT NAME ________________________________ **TELEPHONE** ____________________

PARTNER NAME ________________________________ **TELEPHONE** ____________________

ADDRESS ____

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DATE OF BIRTH______________________

I authorize release of my records from:

☐ Center for Reproductive Medicine
2828 Chicago Ave. S., Suite 400
Minneapolis, MN 55407
Phone: 612-863-5390 Fax: 612-863-2697

☐ Dr. Bruce Campbell ☐ Dr. Paul Kuneck
☐ Dr. Lisa Erickson ☐ Dr. Colleen Casey

☐ Center for Reproductive Medicine
991 Sibley Memorial Hwy, Suite 100
St. Paul, MN 55118
Phone: 651-379-3110 Fax: 651-379-3111

☐ Dr. John Malo

I authorize release of my records to: ____

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INFORMATION TO BE RELEASED

_______ Progress Notes Approximate Dates: ____

_______ Lab Results Approximate Dates: ____

_______ Operative Reports Approximate Dates: ____

_______ Hysterosalpingogram FILM Approximate Dates: ____

Other: ____

PURPOSE OF DISCLOSURE

☐ Continuing Care ☐ Insurance Application ☐ Litigation

☐ Insurance Payment ☐ Personal ☐ Other ____________________

ACKNOWLEDGEMENT OF UNDERSTANDING

- I understand the expiration date of this authorization is 1 year.
- I understand that I may revoke this authorization at any time by notifying the providing organization in writing, and it will be effective on the date notified except to the extent action has already been taken.
- I understand that Center for Reproductive Medicine cannot prevent the redisclosure of records released as a result of this request; therefore Center for Reproductive Medicine is released from any and all liability resulting from redisclosure.
- I understand by authorizing this use or disclosure of information, there will be no conditions placed on my health care or payment for my health care.

____ ____________________ ____________________
Signature of patient or personal representative Relationship Date