AUTHORIZATION TO RELEASE/OBTAIN HEALTH CARE INFORMATION

Patient Name: _____ **DOB:** _____

SSN: _____ **Previous Name:** _____

- ☐ I hereby authorize Aspire Fertility to release my medical records to me
- ☐ I hereby authorize the doctor/provider noted below to send my medical records to:

  Aspire Fertility
  16415 Addison Rd, Ste. 900, Addison, Texas 75001
  Phone: (214) 414-3806 Fax: (214) 414-0376

- ☐ Authorization for Aspire Fertility to send my medical records to the doctor/provider noted below

Doctor/Provider: _____ **Phone Number:**_____

Address: _____

Information to be released:

- ☐ Health care information relating to the following treatment, condition or dates of treatment

  _____

- ☐ All health care information
- ☐ Other: _____

Reason I am requesting Medical Records to be sent:

_____ Transferring Care to another Doctor
_____ Second Opinion _____ Pregnant and need an OB/GYN
_____ Moving _____ Price/Not on my insurance plan _____ Other

I understand that my express consent is required to release any health care Information relating to testing diagnosis, and/or treatment of HIV, sexually transmitted diseases, psychiatric disorders/mental health, or drug and/or alcohol use. If I have been tested, diagnosed or treated for HIV, sexually transmitted diseases, psychiatric disorders/mental health, or drug and/or alcohol use, you are specifically authorized to release all health care information relating to such diagnosis, testing or treatment.

This authorization shall be effective until ten (10) years after my death, unless revoked. I understand that I may revoke this consent for release for medical records at any time except to the extent that action has been taken in reference to it. If I chose to revoke consent, it must be done in writing, addressed to the party authorized to release the records. I understand that information disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state privacy laws. I also understand that a fee for preparing and furnishing this Information will be charged according to rulings set forth by the Texas State Board of Medical Examiners.

Signature: _____ **Date:**_____
(Signature of patient or patient's authorized representative)

Print Name: _____

Relationship to patient (*if signed by anyone other than patient, i.e. parent, spouse, etc.*): _____

Authorization to Fax: ☐ **Yes** ☐ **No**