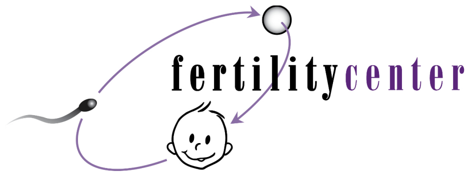


7407 Ziegler Road, Chattanooga, TN 37421 423.899.0500 423.899.2411 (fax)
10408 Jackson Oaks Way, Knoxville, TN 37922 865.692.3433 865.692.3218 (fax)

# AUTHORIZATION TO REQUEST OR RELEASE MEDICAL RECORDS

PRINT PATIENT'S NAME ______________________ PRINT PARTNER'S NAME ______________________

SOCIAL SECURITY NUMBER DATE OF BIRTH SOCIAL SECURITY NUMBER DATE OF BIRTH

☐ **REQUEST FROM**

**OR**

☐ **RELEASE TO**

▶

PHYSICIAN OR FACILITY: ______________________

ADDRESS: ______________________

TELEPHONE AND FAX: ______________________

**Please release my records via (choose one): ☐ Mail to address listed above ☐ I will pick up ☐ Fax to________________**

**PROTECTED HEALTH INFORMATION TO BE RECEIVED OR RELEASED BY DR. JOEY BIRD AND DR. BARRY DONESKY AND THE FERTILITY CENTER STAFF:**

☐ ALL MEDICAL RECORDS ☐ ONLY RECORDS GENERATED BY THE FERTILITY CENTER

☐ LAB RESULTS ☐ ONLY GYNECOLOGY RECORDS

☐ X-RAY AND ULTRASOUND REPORTS ☐ ONLY OBSTETRICAL RECORDS

☐ SURGICAL REPORTS ☐ SEMEN ANALYSES

**EXCLUDE ANY RECORDS THAT REFERENCE THE FOLLOWING:** ______________________

______________________

*I understand that the information used or disclosed by this authorization may be subject to redisclosure by the recipient and is no longer protected by federal privacy regulations. A fax or copy of this authorization may be used with the same effectiveness as an original. Both signatures are required only if information is to be released on both patients. Neither treatment, costs nor any aspect of care from the Fertility Center will be affected by this release. This authorization may be revoked in writing at any time.*

PATIENT'S SIGNATURE ______________________ PARTNER'S SIGNATURE ______________________

DATE ______________________ DATE ______________________

Request completed by ___________________ on_________