Reproductive Science Center
Experience Never Mattered More

PATIENT CONSENT FOR RELEASE OF MEDICAL INFORMATION

Date:
I hereby authorize: _____ (OB-GYN, Fertility Specialist, or Primary Care)
Office Address: _____ City: _____
Phone Number: (_____) _____ Fax Number: (_____) _____

to release to the Reproductive Science Center of the Bay Area our medical records including history and physical, physician notes, laboratory reports, x-rays and any other material regarding consultations and treatment(s) which we have received. This information is requested for the purpose of medical treatment and/or continuity of care.

If the information to be disclosed contains any of the types of records or information listed below, additional laws relating to the use and disclosure of the information may apply. I understand and agree that this information will be used or disclosed if **I place my (and my partner's, if applicable) initials** in the space next to the type of information:

Drug/Alcohol diagnosis, treatment referral information _____ / _____
Mental health information, including provider notes _____ / _____
HIV/AIDS information _____ / _____
Genetic testing information _____ / _____

Please release the requested information to:
The Reproductive Science Center of the Bay Area
Mail: 100 Park Place, Suite 200, San Ramon, CA 94583
eFax: (925) 973-5064
Alternative fax (in case you have difficulty with the eFax line): (925) 820-2254

Physician: _____

Name(Print): _____ Spouse/Partner: _____

Signature: _____ Signature: _____

Date of Birth: _____ Date of Birth: _____

Revocation: This authorization is also subject to written revocation by the undersigned at any time between now and the disclosure of information by the disclosing party. My written revocation will be effective upon receipt, but will not be effective to the extent that the requester or others have acted in reliance upon this authorization.
Redisclosure: I understand that the requester may not lawfully further use or disclose the health information obtained from another health care provider unless another authorization is obtained from me or unless such use or disclosure is specifically required or permitted by law. If this information is disclosed it may not be complete.
Duration: Please process this request within 15 days as provided by law. This authorization shall remain valid for 90 days from the signature below. A copy of this authorization form shall be deemed as valid as an original.