



956-687-2693

Patient:  
Date of Birth:

**Authorization to Release or Obtain Protected Health Information**

Date: \_\_\_\_\_

By signing this form, I authorize you to release/disclose/use protected health information about me, by releasing a copy of my medical records, or a summary or narrative of my confidential protected health information, to the person(s) or entity listed below.

**HIV/AIDS:** I consent to the release of any positive or negative test result for AIDS or HIV infection, antibodies to AIDS or infection with any other causative agent of AIDS with the rest of my medical records.

**Initial:** \_\_\_\_\_ **Date:** \_\_\_\_\_

OBTAIN Information From:		To:	RELEASE Information to:		From:
Name		The Valley's Fertility Center 110 E. Savannah, Suite B103 McAllen, TX 75803 956-687-2693	Name		The Valley's Fertility Center 110 E. Savannah, Suite B103 McAllen, TX 75803 956-687-2693
Address			Address		
Phone			Phone		
Fax			Fax		

**REASON or PURPOSE for request of Medical Records:**

- Request is from a licensed health care provider. Information requested is needed for the provision of acute or emergency care of this patient.
- Other Reason:**

**REQUESTED INFORMATION**

I hereby authorize The Valley's Fertility Center to release or obtain any of the following protected health information:

<input type="checkbox"/>	Operative Report	<input type="checkbox"/>	Pathology Report	<input type="checkbox"/>	Exam Notes	<input type="checkbox"/>	Other:
<input type="checkbox"/>	Lab Results	<input type="checkbox"/>	Pap Smear Results	<input type="checkbox"/>	Mammogram		
<input type="checkbox"/>	Entire Medical Record	<input type="checkbox"/>	Medical History	<input type="checkbox"/>	X-Ray		

**Initial** I understand that this request is valid only if accompanied by payment of the fees indicated below. If payment is not received within 10 days from the date of this request, it will be considered null and void.  
 No Charge – for acute or emergency care.  
 No Charge – less than seven (7) pages and requested by another healthcare provider.  
**(Record will be released as indicated above via the fastest available means.)**  
 \$25.00 up to 20 pages then \$.50 thereafter. Your medical record is \_ pages, cost will be \$ \_\_\_\_\_.  
 Delivery/Shipping fee: \_\_\_\_\_ Total Cost: \$ \_\_\_\_\_.  
**(Record will be released as indicated above within 15 days from receipt of payment.)**

**Initial** I understand that I have the right to revoke this authorization, in writing, at any time by sending a written notification to the following person at the practice:  
 The Valley's Fertility Center, 110 E. Savannah, Suite B103, McAllen, TX 78503 Attn: \_\_\_\_\_

**Initial** I understand that a revocation is not effective to the extent that the practice has relied on this authorization in its actions. Also, a revocation is not effective if this authorization was obtained as a condition of obtaining insurance coverage, as other law provides the insurer with the right to contest a claim under the policy or the policy itself.

\_\_\_\_\_  
 Patient/Guardian/Legal Representative-Signature      Date      Witness Signature      Date