Authorization to Send Medical Records TO Fertility Center of California / Family Fertility Cryobank

This consent authorizes the healthcare provider named below to release confidential medical information and records. Note: Information and medical records regarding treatment to minors, HIV, psychiatric/mental health conditions have special rules that apply and require specific information.

I hereby authorize _____ (physician/group)

to release copies or information regarding my medical history, illness or injury, consultation, prescriptions, treatment, diagnosis or prognosis including X-rays, ultrasounds, correspondence, and/or medical records by means of mail, email, fax or other electronic methods to:

Fertility Center of California / Family Fertility Cryobank
6699 Alvarado Road Suite #2208
San Diego, CA 92120
619-265-0102 or info@fertilityctr.com

This authorization is

- ☐ Unlimited: (all records including substance abuse, mental health, HIV, pregnancy) _____ initials
  OR
- ☐ Medical records EXCEPT the following medical information:

Drug/Alcohol/Substance abuse	_____ initials
Psychiatric/Mental health	_____ initials
STD / HIV	_____ initials
Pregnancy information under 21	_____ initials

Duration: This authorization shall be effective immediately and will remain in effect until ___/___/___.

Restrictions: I hereby agree to the further transfer of my medical information for continuum of care issues or when required by law. A photograph, facsimile or email of this authorization shall be effective and valid as the original. I have been advised of my right to receive a copy of this authorization.

_____ Please print name

_____ Signature

____/____/____ Date

___/___/___ Date of Birth

XXX-XX- _____ Social Security Number

_____ Print Witness Name

_____ Witness Signature

11/13/2018