



**ADVANCED REPRODUCTIVE
MEDICINE & GYNECOLOGY**

407 Uluniu Street, Ste 312
Kailua, HI 96734
808-262-0544
Fax: 808-262-3744



**FERTILITY INSTITUTE
OF HAWAII**

1401 S. Beretania Street, Ste 250
Honolulu, HI 96814
808-545-2800
Fax: 808-262-3744

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

Patient Name: _____ Date of Birth: _____

Phone number: _____ SS#: _____

I authorize:

- John Frattarelli, M.D.**
- Sloane Berger-Chen, M.D.**
- LeighAnn Frattarelli, M.D.**
- Anatte Karmon, M.D.**

to release medical information to the following person(s) for the purpose of continued care:

Name: _____

Phone number: _____ Fax number: _____

RECORDS AUTHORIZED TO BE RELEASED (Note: Please see Disclosures Requiring Special Consent)

Date Range: _____ to _____
 ___ Office/Consult Notes ___ Ultrasounds/Imaging Reports ___ Operative Reports ___ IVF Cycle report(s) ___ Ovulation
 Induction/IUI Notes ___ Lab Reports ___ Other, specify _____

This information will be used for the purpose of:

___ Transferring to New Physician/Continued Medical Care ___ Benefits Application ___ Disability Determination
 ___ Legal Representation ___ Personal Use ___ Other, specify _____

I UNDERSTAND THAT:

- I am not required to sign this authorization and that my health care or payment for care will not be affected by my refusal.
- I am entitled to receive a copy of this authorization.
- Federal privacy regulations will no longer apply to the information disclosed.
- A copy of this authorization may be utilized with the same effectiveness as an original.

EXPIRATION DATE: This authorization is effective for one (1) year from the date signed below unless otherwise indicated. I understand that I can revoke this authorization at any time by contacting Advanced Reproductive Medicine, Inc. or Fertility Institute of Hawaii but that revoking this authorization will not affect disclosures made or actions taken before the revocation is received.

Patient or Representative Signature/Relationship

Date

DISCLOSURES REQUIRING SPECIAL CONSENT:

My signature below specifically authorizes the release of health information relating to testing, diagnosis, and treatment for:
 ___ AIDS/HIV ___ Sexually Transmitted Diseases ___ Alcohol/Drug Use ___ Developmental Disabilities

Patient or Representative Signature/Relationship

Date