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:

Name:_____

Phone number:_____ Fax number:_____

to release medical information to:

☐ **John Frattarelli, M.D.** ☐ **Sloane Berger-Chen, M.D.**

☐ **LeighAnn Frattarelli, M.D.** ☐ **Anatte Karmon, M.D.**

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