Medical Record Request

Encino
15503 Ventura Blvd., Suite 200
Encino, CA 91436
(818) 788-7288
(818) 788-5988 Fax

Fullerton
1950 Sunnycrest Dr., Suite 2400
Fullerton, CA 92835
(714) 738-4200
(714) 738-4496 Fax

Laguna Hills
23961 Calle de la Magdalena
Suite 503
Laguna Hills, CA 92653
(949) 472-9446
(949) 472-3739 Fax

Newport Beach
500 Superior Ave., Suite 210
Newport Beach, CA 92663
(949) 287-5600
(949) 642-2750 Fax

Oceanside
3231 Waring Ct., Suite M
Oceanside, CA 92056
(760) 758-2034
(760) 726-0122 Fax

Pasadena
333 S. Arroyo Pkwy., 3rd Floor
Pasadena, CA 91105
(626) 440-9161
(626) 440-0138 Fax

Rancho Cucamonga
8112 Milliken Ave., Suite 101
Rancho Cucamonga, CA 91730
(909) 941-1120
(909) 941-1125 Fax

Westlake Village
1220 La Venta Dr., Suite 103
Westlake Village, CA 91361
(805) 374-1737
(805) 374-1736 Fax

West Los Angeles
11500 W. Olympic Blvd., Suite 504
West Los Angeles, CA 90064
(310) 481-0881
(310) 481-9017 Fax

www.havingbabies.com

By signing this authorization, I authorize you to use and/or disclose certain protected health information (PHI) about me to:

_____

_____

Dear Dr. _____

I authorize you to release a copy of the medical records of:

_____
Name of Patient

_____ _____
Date of Birth Social Security Number

Covering the period of _____ to _____.

Please fax or send the records to the above address.

The purpose of the requested release is to obtain records related to infertility, or gynecological medical problems. HRC Fertility will not receive payment or other remuneration from a third party in exchange for using or disclosing the PHI.

The specific information requested is office visits, labs, x-rays, surgeries, op reports, etc. The purpose(s) is/are provided so that I can make an informed decision whether to allow release of the information.

This authorization will expire on _____/_____/_____.

I release you from all legal responsibility or liability that may arise from this authorization.

I do not have to sign this authorization in order to receive treatment from HRC Fertility. In fact, I have the right to refuse to sign this authorization. When my information is used or disclosed pursuant to this authorization, it may be subject to redisclosure by the recipient and may no longer be protected by the federal HIPAA Privacy Rule. I have the right to revoke this authorization in writing except to the extent that the practice has acted in reliance upon this authorization. My written revocation must be submitted to the Privacy Officer at HRC's Pasadena office.

Please release my medical records, including:

❑ HIV/Drug screen ❑ Psychotherapy Notes ❑ All my medical records

❑ My laboratory results for _____ ❑ All my laboratory results

❑ Please exclude the following _____

Fees for obtaining medical records if the chart is not in storage: $ .25 per page

Fees for obtaining medical records if the chart is in offsite storage facility: $75

_____
Patient Name (please print)

_____ _____
Patient Signature Date