Release to Self

I _____ hereby authorize the release and /or disclose of my medical information as indicated below to the healthcare provider, entity, or individual I have listed below with the following information for the purpose of _____ :

__✖__ All Medical Records pertaining to my medical history, physical condition, and treatment received

____ Obstetrical Records ____GYN Records ____ Labs Only

____ Billing Records __✖__ All Infertility Records (Inclusive of IVF Lab Records if applicable)

__✖__ Frozen Eggs and/or Embryo Storage Information __✖__ Frozen Semen/TESE & Storage Information

Limitations if any _____

Records are to be released from: Western Fertility Institute
16260 Ventura Blvd., Suite 210
Encino, CA 91436
Fax: 818.292.8914

Records are to be release to: _____
_____
_____
Fax: _____

This authorization shall become effective immediately and shall remain in effect until _____(enter date) or for one year from the date of signature if no date entered.

I understand that by signing this authorization:

- I authorize the use or disclosure of my individually identifiable health information as described above for the purpose listed.
- I have the right to withdraw permission for the release of my information. If I sign this authorization to use or disclose information, I can revoke that authorization at any time. The revocation must be made in writing and will not affect information that has already been used or disclosed.
- I have the right to receive a copy of this authorization.
- I am signing this authorization voluntarily and treatment, payment, or my eligibility for benefits will not be affected if I do not sign this authorization.
- I further understand that a person to whom records and information are disclosed pursuant to this authorization may not further use or disclose the medical information unless another authorization is obtained from me or unless such disclosure is specifically required or permitted by law.

_____ _____
SSN Date of Birth

_____ _____
Signature of patient or patient representative Indicate Relationship (If other than Patient Signature)

Authorization Date _____