Fertility Specialists Medical Group
8010 Frost Street, Suite P
San Diego, CA 92123
(858)505-5500 Fax (858)505-5555

Authorization for FSMG to Release Medical Information/Records

This authorization to release medical information is in accordance to the Confidentiality of Medical Information Act of 1981, Section 56 et seq, of the California Civil Code.

I hereby authorize Fertility Specialists Medical Group, Inc. to communicate with and release summary letters, medical records including laboratory test results, ultrasound reports and office visits to the following:

Please exclude the following items: _____

OB/Gyn Name_____

Address _____

Phone _____ Fax _____

Primary Care Name_____

Address _____

Phone _____ Fax _____

Partner MD Name_____

Address _____

Phone _____ Fax _____

Other Name_____

Address _____

Phone _____ Fax _____

This authorization is □ **ongoing or** □ **effective through ____ /____ /____** unless revoked or terminated by the patient or patient's personal representative. You may revoke or terminate this authorization by submitting a written revocation to the attention of the Privacy Officer of Fertility Specialists Medical Group.

Information that is disclosed under this authorization may be disclosed again by the person or organization to whom it is sent. The privacy of this information may not be protected under federal privacy regulations.

Patient Label or
Name
_____
DOB _____/_____/_____

Signature _____
Date _____ /_____ /_____

Patient Label or
Name
_____
DOB _____/_____/_____

Signature _____
Date _____ /_____ /_____