Midwest Fertility Specialists

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Request for an Individual's Health Information

Last: **First:** **Middle:**

Other Name Used: **Date of Birth:** **SS#:**

Address:

Home Phone: ( ) **Work Phone: ( )**

□ I hereby request access to the protected health information in my health record from (date) _____ to (date) _____

[ ] Most recent Progress Note
[ ] Pathology/Lab Reports
[ ] U/S Reports
[ ] Billing Records
[ ] Entire Health Record
[ ] Other_____

[ ] I will pick up the copies of my records
[ ] Mail copies of my records to the individual noted below :

Records From:	**Records To:**
Name:	Name:
Address:	Address:
Phone:	Phone:
Fax:	Fax:

Purpose of Request: __patient's request, __dispute, __referral, __other: _____

I understand:

- I may revoke this authorization at any time by providing my written revocation to Midwest Fertility Specialists. My revocation will not apply to information already retained, used or disclosed in response to this authorization. Unless revoked, the automatic expiration date will be six (6) months from the date of signature.

Signature of patient or legal representative Date

- HIV and AIDS Information Authorization: Specific authorization is required for HIV-related information. Please sign below to release this information

Signature of patient or legal representative Date

Form: 277M