



Authorization for Release of Medical Information

NYU Fertility Center

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I, or my authorized representative, request(s) that medical information regarding my care and treatment at NYU Fertility Center (NYUFC) be released to the party named below.

I understand that this consent may include disclosure of information relating to **alcohol or drug abuse, psychiatric care and/or confidential HIV-related information** and in the event the medical information described below contains information relating to **alcohol or drug abuse, psychiatric care and/or confidential HIV-related information**, I specifically authorize release of such information to the person(s) indicated below. I also understand that I will have the right to cancel this release at any time. I also understand that my consent to release information will expire one (1) year from this date.

I understand that under New York state law, except for certain people, confidential HIV-related information can only be given to the person(s) I allow to have it by signing a release.

Please print clearly the following information:

Name of Patient (Please print)			Date of Birth	Last 4 Digits of SSN
Name, address and telephone number of the person you are designating to receive information:				
Specific information to be released:				
<input type="checkbox"/> All medical records from _____ to _____ including HIV and genetic test results.				
<input type="checkbox"/> Blood tests only – specify: _____				
<input type="checkbox"/> Surgical report(s) – specify: _____				
<input type="checkbox"/> As described: _____				
Reason for release of information:				

My questions about this form have been answered. I know that I can decline the release of information and I can change my mind at any time. I understand that this request will be fulfilled by mail within 10 days.

Signature of Patient or Authorized Representative

Date

Relationship of Representative

