



Authorization for Request of Medical Information to NYUFC

I, or my authorized representative, request(s) that medical information regarding my care and treatment at _____ 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 _____	Social Security Number _____
Name, address and telephone number of the person you are designating to receive information:		
<input type="checkbox"/> A. Berkeley <input type="checkbox"/> J. Grifo <input type="checkbox"/> F. Licciardi <input type="checkbox"/> N. Noyes <input type="checkbox"/> D. Keefe <input type="checkbox"/> M. E. Fino <input type="checkbox"/> L. Kump-Checcio		
NYU Fertility Center 660 First Avenue, 5th Floor New York, NY 10016-3295 T: 212.263.8990 F: 212.263.7853		
Specific information to be released:		
<input type="checkbox"/> All medical records from _____ to _____		
<input type="checkbox"/> Blood tests only		
<input type="checkbox"/> Surgical report(s)		
<input type="checkbox"/> As described: _____		
Reason for release of information:		

Signature of Patient or Authorized Representative

Date

Relationship of Representative