



**ADVANCED REPRODUCTIVE
MEDICINE & GYNECOLOGY**

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**FERTILITY INSTITUTE
OF HAWAII**

1401 S. Beretania Street, Ste 250
Honolulu, HI 96814
808-545-2800
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AUTHORIZATION TO RELEASE MEDICAL INFORMATION

Patient Name: _____ Date of Birth: _____

Phone number: _____ SS#: _____

I authorize:

Name: _____

Phone number: _____ Fax number: _____

to release medical information to:

John Frattarelli, M.D.

Sloane Berger-Chen, M.D.

LeighAnn Frattarelli, M.D.

Anatte Karmon, M.D.

RECORDS AUTHORIZED TO BE RELEASED (Note: Please see Disclosures Requiring Special Consent)

Date Range: _____ to _____

Office/Consult Notes Ultrasounds/Imaging Reports Operative Reports IVF Cycle report(s) Ovulation Induction/IUI Notes Lab Reports Other, specify _____

This information will be used for the purpose of:

Transferring to New Physician/Continued Medical Care Benefits Application Disability Determination

Legal Representation Personal Use Other, specify _____

I UNDERSTAND THAT:

- I am not required to sign this authorization and that my health care or payment for care will not be affected by my refusal.
- I am entitled to receive a copy of this authorization.
- Federal privacy regulations will no longer apply to the information disclosed.
- A copy of this authorization may be utilized with the same effectiveness as an original.

EXPIRATION DATE: This authorization is effective for one (1) year from the date signed below unless otherwise indicated. I understand that I can revoke this authorization at any time by contacting Advanced Reproductive Medicine, Inc. or Fertility Institute of Hawaii but that revoking this authorization will not affect disclosures made or actions taken before the revocation is received.

Patient or Representative Signature/Relationship

Date

DISCLOSURES REQUIRING SPECIAL CONSENT:

My signature below specifically authorizes the release of health information relating to testing, diagnosis, and treatment for:

AIDS/HIV Sexually Transmitted Diseases Alcohol/Drug Use Developmental Disabilities

Patient or Representative Signature/Relationship

Date