



ADVANCED REPRODUCTIVE  
MEDICINE & GYNECOLOGY

407 Uluniu Street Suite 312  
Kailua HI 96734  
808-262-0544  
Fax-808-262-3744



FERTILITY INSTITUTE  
OF HAWAII

1401 S. Beretania Street Suite 250  
Honolulu HI 96814  
(808) 545-2800  
Fax-808-262-3744

**AUTHORIZATION TO RELEASE MEDICAL INFORMATION**

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Phone number: \_\_\_\_\_ SS#: \_\_\_\_\_

**I authorize:**

- John Frattarelli, M.D.
- Emily Goulet, M.D.
- LeighAnn Frattarelli, M.D.
- Anatte Karmon, M.D.

to release medical information to the following person(s) for the purpose of continued care:

Name: \_\_\_\_\_

Phone number: \_\_\_\_\_ Fax number: \_\_\_\_\_

**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