ADVANCED REPRODUCTIVE MEDICINE & GYNECOLOGY
407 Uluniu Street Suite 312
Kailua HI 96734
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1401 S. Beretania Street Suite 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:

Doctor's name:_____

Phone number:_____ Fax number:_____

to release medical information to:

☒ **John Frattarelli, M.D.** ☒ **Emily Goulet, 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