ADVANCED REPRODUCTIVE MEDICINE & GYNECOLOGY
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FERTILITY INSTITUTE OF HAWAII
1401 S. Beretania Street Suite 250
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(808) 545-2800
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Patient – Partner Release of Medical Information Consent

I hereby authorize:

Advanced Reproductive Medicine and Gynecology of Hawaii, Inc.
&
Fertility Institute of Hawaii

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

To release my medical records to my spouse/partner for the purpose of sharing information as it relates to my treatment plan. His/her name and contact information is as follows:

Name:_____

Address:_____

Phone Number:_____E-mail:_____

Description of information: Disclosure is authorized for any and all medical information including physicians' notes, operative reports, laboratory results, pathology results, and radiology reports unless otherwise specified.
Duration: This authorization is valid for one year from the date of the signing unless revoked in writing by the undersigned within one year.

Patient Name:_____ Date of Birth:_____

Phone number:_____

_____ _____
Patient Signature Date