DOXOLOGY
HEALTH & FERTILITY

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Medical Record Release Form

Patient Name: _____ SSN: _____

Address: _____

Date of Birth: _____ Phone #: _____

I authorize Doxology Health and Fertility to release copies of my confidential medical records to:

Name:_____

Address: _____

City: _____ State: _____ Zip: _____

Phone #: _____ Fax #: _____

My authorization extends to the following:
_____ All records
_____ Progress notes
_____ Mammogram/Bone density
_____ Lab/Pathology reports
_____ Xray/Sonogram Reports
_____ Other (please specify) _____

The information will be used or disclosed for the following purpose:
____ Continuity of Care _____ Personal Use _____ Second opinion ____ Transfer of care

This authorization is given voluntarily with the understanding that:

1. My treatment will not be impacted by signing this authorization
2. I will receive a copy of this authorization upon signature.
3. I have the right to revoke consent of disclosure in writing up to and until the records are released by Doxology Health and Fertility.
4. This consent is valid for 30 days from the date of signature.
5. There may be a fee for preparing this information.
6. Once my health information is disclosed as requested, it may no longer be protected by federal and state privacy laws and could be re-disclosed by the person(s) receiving it. I hereby release Doxology Health and Fertility from any legal liability that may arise from the release of this information to the above-named party.

Name (print): _____

Signature: _____ Date: _____

Guardian/Authority of Representative is Signing for the Individual _____