



CRM

CENTER FOR REPRODUCTIVE MEDICINE (407) 740-0909

Gary W. DeVane, M.D., Randall A. Loy, M.D.,

Sharon B. Jaffe, M.D., Sejal Dharja Patel, M.D.

Orlando, FL Celebration, FL Lake Mary, FL

AUTHORIZATION TO OBTAIN MEDICAL RECORDS

CRM Appointment Date and Time: _____

AUTHORIZATION TO OBTAIN, RELEASE OR REVIEW PROTECTED HEALTH INFORMATION

I, _____ (patient) hereby authorize

(Name of Facility or Physician)

to (check one): **release copies** **allow review** **obtain records**

of the medical record of: _____
(Print complete patient name)

for the purpose of (check one): **continuing medical care** **personal records** **other:** _____

including dates of service _____ through _____

to: **Center for Reproductive Medicine**
3435 Pinehurst Avenue, Orlando, FL 32804
Phone 407-740-0909; Fax 407-740-7262

Requested Records (please initial all that apply):

- _____ Consultation Reports
- _____ All Operative Reports and Other Procedure Reports
- _____ Lab, Diagnostic Test Results (including HIV, Hepatitis and Semen Analysis), X-Ray (Hysterosalpingogram) Reports and Actual Films (if available)
- _____ History and Physical
- _____ Physician's and Nurses' Progress Notes
- Other _____

I understand that this consent may be withdrawn at any time and shall expire ninety (90) days after the date indicated below. I further agree that a photocopy or facsimile copy of this authorization shall be as effective as the original.

Patient Full Name (please include any alternate names you may have used as a patient): _____

Patient Signature: _____ Date: _____

Patient Birth date: _____ Social Security Number: _____

PLEASE RETURN A COPY OF THIS FORM WITH RECORD