



CRM

**CENTER FOR
REPRODUCTIVE
MEDICINE**

Gary W. DeVane, M.D.

Randall A. Loy, M.D.

Sharon B. Jaffe, M.D.

Sejal Dharia Patel, M.D.

Board Certified

Reproductive Endocrinology
and Infertility

Linda Jones, RNC, ARNP

Reproductive Endocrinology
and Infertility Nurse Practitioner

B.K. Gangrade, Ph.D.

Chief Embryologist

Anna Sosa, E.S., T.S.

Embryologist

RECORDS RELEASE AUTHORIZATION

I hereby authorize Gary W. DeVane, M.D., Randall A. Loy, M.D., Sharon B. Jaffe, M.D., Sejal Dharia Patel, M.D., or the Center for Reproductive Medicine, P.A. to release pertinent medical records to me, including, but not limited to (strike through any records that are **not** to be copied):

- | | |
|---|--|
| <input type="checkbox"/> Discharge summaries | <input type="checkbox"/> Notes on alcohol or substance abuse |
| <input type="checkbox"/> Operative reports from surgery | <input type="checkbox"/> Entire file (except previous physician's records) |
| <input type="checkbox"/> Pathology reports | <input type="checkbox"/> Notes on psychiatric counseling |
| <input type="checkbox"/> Radiology reports | <input type="checkbox"/> Lab results (including HIV testing or AIDS information) |
| <input type="checkbox"/> Office notes | |

Reason for release: _____

Date of request: _____

Patient full name (include any alternate name that you may have used as a patient):

Patient DOB: _____ Patient SS#: _____

To better help us serve our patients, we would appreciate knowing the reason you are requesting your records:

- | | |
|---|--|
| <input type="checkbox"/> Insurance documentation | <input type="checkbox"/> Change of insurance company |
| <input type="checkbox"/> Consulting new physician/2 nd opinion | <input type="checkbox"/> Moving out of area |
| <input type="checkbox"/> Primary care physician request | <input type="checkbox"/> Personal records |
| <input type="checkbox"/> Returning to OB/GYN | |

- ***I understand that records will only be released to me, the patient, and not to any other physician office***
- ***I understand that a new request must be signed each time records are requested***
- ***I understand that there will be no charge for the first request for copies. Should I request additional copies, I will be charged in accordance with Florida Statutes.***

Patient Signature: _____ Witness: _____

Copy date: _____ Copied by (initials): _____

Records mailed on: _____ Patient picked up records on: _____