



1775 East Skyline Drive
Tucson, Arizona 85718
(520) 222-8400
(520) 219-2351

MEDICAL RECORD RELEASE
ARI AUTHORIZATION FOR USE AND DISCLOSURE OF
PROTECTED HEALTH INFORMATION (PHI)

This Authorization is according to Federal Privacy Laws.

Patient Information:

Last Name First Middle
Maiden Name Address
City State Zip
SS Number Date of Birth Phone

I, the above identified person, do hereby authorize the release of my PHI as indicated - Identify individual/group/entity and list addresses.

From:

To: Christine Mansfield, MD.

Arizona Reproductive Institute
1775 East Skyline Drive, Suite 175
Tucson, AZ 85718
P: (520) 222-8400 F: (520) 219-2351

I understand that this authorization is voluntary and that it may include information relating to AIDS, HIV infection, behavioral health services/psychiatric care, and treatment for alcohol and/or drug abuse. I understand that if the person/entity that receives my Protected Health Information is not covered by Federal Privacy regulations, the PHI described below may be re-disclosed by such person or entity. I understand that I may refuse to sign this authorization. My refusal to sign will not affect my ability to obtain treatment or payment or my eligibility for benefits unless the treatment is for research purposes or unless the provision of treatment is related solely to the disclosure of my PHI to a third party such as when requested by my employer.

This authorization covers the following periods of healthcare:

All Periods of Healthcare From To

Protected Health Information (PHI) to be used or disclosed (check box or boxes):

- Female Patients: Lab reports including: STI's, Pap, Thyroid Panel, Prolactin, Rubella, Varicella, Clotting Panels, Karyotypes, Genetic Testing, Blood Type, etc
History & Physical
Consultation Reports
Radiology Reports and Images-HSG Films
Previous Treatment Cycle (Timed Intercourse, IUI,IVF,PGD-PGS) flowsheets, embryology records and medications protocol
Operative Report- D&C, Hysteroscopy, Laparoscopy, Tubal Ligation and images
Male Patients: Lab reports including: S'TI's and Semen Analysis
Psychotherapy Notes
Other (please specify)

This information is being disclosed for the following purposes:

- Legal Reasons
Continued Care and Treatment
Obstetrical Care
At the Request of the Patient
Insurance
Workman's Compensation
Personal Use
Disability

Other (Explanation)

This Authorization will expire in one year unless otherwise specified:

I understand that I/my legal representative may revoke this authorization in writing at any time, except to the extent that action has already been taken in reliance on this authorization or according to law. Written revocation must be sent to the person that I authorized to release my information.

I hereby certify that I have read the provisions set forth in this authorization. I understand and agree to its terms.

Patient Signature Date