GENETICS & IVF
Institute

INFORMATION ABOUT MEDICAL RECORDS REQUESTS

GIVF is happy to facilitate your request for a copy of your medical records. Due to the costs associated with retrieving and copying records, we now must charge the rates allowed for under state law.

These rates are:

- $10 fee for search and handling of all records stored in paper or electronic form on premises at GIVF
- $20 fee for search and handling of all records stored offsite in paper form
- $0.50 per page for up to 50 pages and $0.25 thereafter
- All applicable postage and shipping costs

All records will be produced in paper format.

Please allow up to 30 days from the date of receipt for your request to be processed.

NOTE: Your health record may include information related to sexually transmitted disease, acquired immune deficiency syndrome (AIDS), Human Immunodeficiency Virus (HIV), behavioral or mental health services, and/or treatment for alcohol and drug abuse. By requesting that we create a copy of your medical records, you are authorizing us to release that information.

Please submit completed forms to GIVF via DocuSign (link available on our website) or by giving a paper copy to our front desk staff or mailing a copy to the address listed on the form.

Medical Records Request Form on Next Page

GENETICS & IVF
Institute

AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

Patient Name: _____ **Date of Birth:** _____

Address: _____

Telephone: _____

I authorize the use or disclosure of my protected health information as described below:

Specify the information that may be disclosed:

- ❑ Medical records ❑ Billing records ❑ Lab Results
- ❑ All of each type checked above
- ❑ All of each type checked above between the dates of _____ and _____
- ❑ Only records pertaining to _____

_____

_____

I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), human immunodeficiency virus (HIV), behavioral or mental health services, and/or treatment for alcohol and drug abuse.

The information identified above may be released to the following individual/entity:

Name: _____

Address: _____

_____

Telephone: _____

Purpose of Disclosure_____.

I understand that I have the right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to GIVF's Privacy Officer. I understand that my revocation will not apply to information that has already been released in accordance with this authorization. This authorization will expire (insert date or event): _____. If no date or event is listed, this authorization will remain in effect until I revoke it.

I understand that once the above information is disclosed, it may be re-disclosed by the recipient and may no longer be protected by federal privacy laws or regulations. I also understand that I am not required to give this authorization in order to receive medical treatment.

I understand that all records will be produced in paper form at the cost of $0.50 per page up to 50 pages and $0.25 thereafter. I understand that there is also a $10 fee for search and handling of records stored on premises at GIVF and a $20 fee for search and handling of records stored offsite.

PLEASE CHECK IF YOU WOULD LIKE US TO MAIL A COPY OF YOUR RECORDS:

❑ I request that a copy of my medical records be mailed to the individual or entity named above.

If signed by legal representative: By signing this form, I represent and warrant that I have authority to sign this document. Evidence of legal representative's authority to sign this form must be provided to GIVF upon request.

Patient or Legal Representative Signature:_____ **Date**: _____