GIVF Fertility

3015 Williams Drive, | Fairfax, VA 22031 | 703-698-7355 | www.givffertility.com

# Information About Medical Records Requests

GIVF Fertility is happy to facilitate your request for a copy of your medical records. Due to the many required steps associated with this process, we assess a fee for all patient requests for medical records in accordance with state and federal law.

These rates are:

- $10 processing fee for all records stored onsite, plus $0.50 per page for up to 50 pages and $0.25 per page thereafter.
- $20 processing fee for search and handling of all records stored offsite, plus $0.50 per page for up to 50 pages and $0.25 thereafter
- All applicable postage and shipping costs apply to records sent by USPS mail

**Electronic medical records request must be accompanied by valid photo ID**

Records are available by:

- In-person pick-up with Photo ID
- Fax
- USPS mail
- Email (only if the patient is recipient)

If requesting your records **and** your partner's records, please submit a **separate** medical record release request form for each set of records.

**Please allow up to 30 days from the date of receipt in the Medical Records Dept. for your medical record request to be processed.**

Completed Medical Record Release forms can be:

- Faxed to (703) 991-8030
- Dropped off at the GIVF Fertility front desk
- Emailed to medicalrecords@givffertility.com; or
- Mailed to GIVF Fertility, Attn: Medical Records
  3015 Williams Dr., Suite 300
  Fairfax, VA 22031

**Medical Records Request Form on Next Page**

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# MEDICAL RECORDS REQUEST FORM

**Return request form to medicalrecords@givffertility.com or Fax (703) 991-8030**

| | |
|---|---|
| Patient Full Name: | Date of Birth: |
| Email Adress: | Phone Number: |
| Street Address: | City, State, Zip Code: |

I am requesting records for the time period dating from _____ **to** _____ *(required)*

- ☐ Lab Report
- ☐ Ultrasound Report
- ☐ Consultation Notes
- ☐ Genetic Report
- ☐ Entire Medical Record – check **only** for ALL records
- ☐ Pathology Report
- ☐ Embryology Report
- ☐ Donor ID **(specify info below. Donor records are NOT stored or processed by GIVF Fertility)**
- ☐ Only records pertaining to **(specify):** _____

**Purpose of request**: ☐ Transferring Care ☐ Continuing to OB Care ☐ Billing/ Insurance ☐ Legal Purposes ☐ Personal Record

I hereby authorize **GIVF Fertility** to disclose the records specified above to the following individual or entity:

***A copy of your photo ID must be accompanied with all electronic requests***

I request records be released by the following method:

- ☐ In person pick-up (**photo ID required**)
- ☐ Mail via USPS
- ☐ Email _____ **(permitted only if the patient is recipient)**
- ☐ Fax _____

To: _____
Name of Person / Facility

_____
Phone Number

_____
Street Address

_____
City/ State/ Zip Code

I understand that the information in my health records may include information related to AIDS and/or HIV, sexually transmitted diseases, genetic testing, psychiatric/mental health services, and/or treatment for drug and alcohol abuse. By requesting the release of these records, I authorize GIVF Fertility to release that information.

I hereby authorize disclosure of health information for the above-named patient. This authorization is valid for 12 months from the date of signature. I understand that I may cancel this request at any time by submitting a request in writing to GIVF Fertility, Attn: Medical Records, 3015 Williams Drive, Suite 300, Fairfax, Virginia 22031. In the event my information has already been shared, this revocation will not affect any information released prior to GIVF Fertility's receipt of my notice of revocation. I understand that the information used or disclosed may no longer be protected by federal privacy laws once it is released to this recipient. I further understand that this authorization is voluntary and that I am not required to give authorization in order to receive medical treatment.

**I understand that there is a $10 processing fee for all records stored on premises at GIVF Fertility, plus a charge of $0.50 per page for up to 50 pages and $0.25 per page thereafter. For any records stored off-site, a $20 processing fee for search and handling of records will apply, plus $0.50 per page for up to 50 pages and $0.25 per page thereafter.**

_____ _____

**Patient / Legal Representative Signature** **Date**

*If signed by the 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 (such as power of attorney, court order appointing representative as guardian or executor of estate) must be provided to GIVF Fertility.*

**Note: Please allow up to 30 days for the completion of your request**