CONCEPTIONS
REPRODUCTIVE ASSOCIATES OF COLORADO

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AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Conceptions Reproductive Associates will provide a copy of medical dictation and/or results directly generated by our center. To assure a complete copy of medical records for services rendered outside of the Conceptions Reproductive Associates office; patients must initiate a separate medical release request to the rendering physician(s), hospital and/or laboratory directly.

Patient Name: _____ *Date of Birth:* _____

Address: _____ *Phone Number:* _____

_____

I request and authorize (name of doctor/practice): _____

Phone: _____ *Fax:* _____

to release healthcare information of the patient named above to:

Name: _____

Address: _____

City: _____ *State:* _____ *Zip Code:* _____

Phone: _____ *Fax:* _____

☐ *Specific healthcare information relating to the following treatment, condition, or dates:*

_____

☐ *All healthcare information directly generated by Conceptions Reproductive Associates*

Definition: *Sexually Transmitted Disease (STD) as defined by law, RCW 70.24 et seq., includes herpes, herpes simplex, human papilloma virus, wart, genital wart, condyloma, Chlamydia, non-specific urethritis, syphilis, VDRL, chancroid, lymphogranuloma venereuem, HIV (Human Immunodeficiency Virus), AIDS (Acquired Immunodeficiency Syndrome), and gonorrhea.*

☐ *Yes* ☐ *No* *I authorize the release of my STD results, HIV/AIDS testing, whether negative or positive, to the person(s) listed above. I understand that the person(s) listed above will be notified that I must give specific written permission before disclosure of these test results to anyone.*

☐ *Yes* ☐ *No* *I authorize the release of any records regarding drug, alcohol, or mental health treatment to the person(s) listed above.*

I understand that I have the right to revoke this authorization at any time by written notification to Conceptions, except to the extent that action has already been taken. I understand that this consent will expire 90 days from the date of my signature, unless I provide notice in writing to revoke. I also understand that the written revocation must be signed and dated later than the date on this authorization. I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law.

Patient Signature: _____ *Date:* _____

Witness: _____ *Date:* _____

Please allow 7 – 10 business days to process medical records