Ohio Reproductive Medicine

4830 Knightsbrigde Blvd, Suite E
Columbus, OH 43214
Phone (614) 451-2280
Fax (614) 451-4352
www.ohioreproductivemedicine.com

Authorization for Release of Medical Information
Please Allow 5 to 7 business days

Date of Request: _____

Patient Name: _____ Patient #: _____

Date of Birth: _____ SSN: _____

Address: _____City, State, Zip_____

ORM Physician: _____

I hereby authorize Ohio Reproductive Medicine to release the following from my medical records:

☐ Only the following tests or records:
_____
_____

☐ Complete Medical Records (which may include mental and psychiatric health; drug or alcohol abuse; human immunodeficiency virus (HIV); Acquired Immunodeficiency Virus (AIDS); and AIDS related complex (ARC); Genetics testing and genetics counseling.

I understand I am not required to release genetic testing or counseling results.

Release the above information to:

Full Name: _____

Address: _____ City, State, Zip: _____

Phone Number _____ Fax Number (if possible) _____

Purpose of the release: _____ ❑ Pick up in office

This authorization is valid for 90 days from the date of signature. It may be revoked in writing by the undersigned at any time prior to the release of the information from the disclosing party. The requester may not lawfully further use or disclose the health information unless another authorization is obtained, unless disclosure is specifically required or permitted by law. If The patient may inspect or copy the protected health information used or disclosed pursuant to authorization and may refuse to sign this authorization. The patient shall receive a copy of this authorization upon request

_____

Patient's Signature **Date**

_____

Spouse's Signature (blood work and semen analysis) **Date**

Laura Londra, M.D.
Elizabeth A. Kennard, M.D.
Brooke Rossi, M.D.
Grant Schmidt, M.D., Ph.D.
Steven Williams, M.D.