Ohio Reproductive Medicine

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

535 Reach Blvd., Suite 200, Columbus, OH 43215 | Phone: (614) 451-2280 | Fax: (614) 451-4352

Authorization for Release of Medical Information

Date of Request: _____ Patient #: _____ Date of Birth: _____

Patient Name: _____ SSN: _____

Address: , _____ Phone: _____

City: _____ State: _____ Zip: _____

Medical Professional/Clinic/Hospital to release information:

_____

Phone: _____ FAX: _____
(**Required if request is to be faxed to provider)

I hereby authorize the release of the following from my medical records:

☐ HSG Films/Disk ☐ Operative Notes

☐ Lab Results ☐ Pathology Report

☐ Medication List ☐ Semen Analysis

Submit information to:
Ohio Reproductive Medicine
535 Reach Blvd., Ste. 200
Columbus, Ohio 43215
Phone: 614-451-2280 | **Fax: 614-451-4352**

Please forward before my appointment on: _____

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.

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/Partner Signature (**Required for their records including Semen Analysis) Date