



# Ohio Reproductive Medicine

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### 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:

If you would like to pick up your medical records in our office.

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: \_\_\_\_\_

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**

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