THE NEW HOPE CENTER FOR REPRODUCTIVE MEDICINE
A DIVISION OF MAWC, PLC

AUTHORIZATION for RELEASE of PATIENT MEDICAL INFORMATION

ATTN: _____ PHONE: _____

_____ FAX: _____

I HEREBY AUTHORIZE THE ABOVE PARTY TO RELEASE THE FOLLOWING MEDICAL INFORMATION TO:

The New Hope Center for Reproductive Medicine / Robin L. Poe-Zeigler, M.D.

448 VIKING DRIVE, OCEANA PLACE- VIRGINIA BEACH, VA 23452 / PHONE: (757) 496-5370 / FAX: (757) 481-3354

PATIENT NAME: _____ DATE OF BIRTH: _____

SSN: _____ PHONE: _____ LAST APPT. DATE: _____

FORMER NAME IF APPLICABLE: _____

THIS INFORMATION SHOULD INCLUDE BUT NOT BE LIMITED TO THE FOLLOWING:

FEMALE

- ☐ OPERATIVE REPORTS
- ☐ HSG REPORTS AND FILMS
- ☐ STIMULATION SHEETS FROM OVULATION INDUCTION AND IVF CYCLES
- ☐ POST-COIATAL RESULTS
- ☐ HORMONAL STUDIES (FSH, LH, TSH, PRL ETC.)
- ☐ DELIVERY NOTES
- ☐ LAB TEST INCLUDING: CURRENT PAP, ANTISPERM AB'S, RUBELLA, ETC.
- ☐ OTHER: ANY OTHER RECORDS THAT PERTAIN TO THIS PATIENTS TREATMENT IN YOUR OFFICE

MALE

- ☐ SEMEN ANALYSIS (INCLUDING MORPHOLOGY)
- ☐ SPERM FUNCTION TESTING RESULTS
- ☐ INTRA-UTERINE INSEMINATION RESULTS
- ☐ UROLOGY: OPERATIVE REPORTS

This authorization expires exactly one year from the date which it is signed. The patient has the right to cancel this authorization at anytime. Cancellation of this authorization must be submitted in writing. Each New Hope Center patient is provided with a copy of full HIPAA privacy policy guidelines in their new patient packet. If you have any questions and would like an additional copy of the HIPAA guidelines you may request one at anytime.

_____ _____

PATIENT SIGNATURE (PARENT OR GUARDIAN OF MINOR) DATE

_____ _____

WITNESS DATE