Mark R. Bush, M.D., FACOG, FACS
Robert A. Greene, M.D., FACOG
Natalia Grindler, M.D., FACOG
Althea M. O'Shaughnessy, M.D., FACOG
Jasmine L. Chiang,M.D., FACOG

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 10 – 14 business days to process medical records

271 W County Line Rd Littleton. CO 80129 T: 303.794.0045 F: 303.794.2054	4500 E. 9th Avenue, Suite 630 Denver, CO 80220 T: 303.720.7887 F: 720.763.9140	300 Exempla Cir., Suite 370 Lafayette, CO 80026 T: 303.449.1084 F: 303.449.1039	10107 RidgeGate Pkwy, Suite 300 Lone Tree, CO 80124 T: 303.586.6598 F: 720.459.5112