NYU Langone MEDICAL CENTER

Authorization for Request of Medical Information to Fertility Center at NYULMC

I, or my authorized representative, request(s) that medical information regarding my care and treatment at _____ be released to the party named below.

I understand that this consent may include disclosure of information relating to ***alcohol or drug abuse, psychiatric care and/or confidential HIV-related information*** and in the event the medical information described below contains information relating to ***alcohol or drug abuse, psychiatric care and/or confidential HIV-related information***, I specifically authorize release of such information to the person(s) indicated below. I also understand that I will have the right to cancel this release at any time. I also understand that my consent to release information will expire one (1) year from this date.

I understand that under New York state law, except for certain people, confidential HIV-related information can only be given to the person(s) I allow to have it by signing a release.

Please print clearly the following information:

_____ _____ _____

Name of Patient (Please print) *Date of Birth* *Social Security Number*

Name, address and telephone number of the person you are designating to receive information:

☐ A. Berkeley ☐ J. Grifo ☐ F. Licciardi ☐ N. Noyes

☐ D. Keefe ☐ M. E. Fino ☐ B. Hodes-Wertz ☐ K. Goldman ☐ L. Kump-Checcio

Fertility Center at NYULMC

660 First Avenue, 5th Floor

New York, NY 10016-3295

T: 212.263.8990 F: 212.263.7853

Specific information to be released:

☐ All medical records from _____ to _____

☐ Blood tests only

☐ Surgical report(s)

☐ As described: _____

Reason for release of information:

_____ _____

Signature of Patient or Authorized Representative *Date*

_____

Relationship of Representative