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AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

I (We) hereby authorize release of my (our) medical records from Delaware Institute for Reproductive Medicine, P.A.

Please Note the Following:

- Only records generated by our office will be released.
- There will be a fee for preparation of medical records:
  - Disc or electronic fax - $25.00
  - Paper - Delaware Medical Society Fees: http://dpr.delaware.gov/boards/medicalpractice/record_fees.shtml
- This authorization is valid for 12 months from original signature date.

Records to be released to: _____
Address: _____
City/State/Zip: _____
Patient Name (Print): _____
Patient Date of Birth: _____
Patient SS#: _____

Partner records to be released to: _____
Address: _____
City/State/Zip: _____
Partner Name (Print): _____
Partner Date of Birth: _____
Partner SS#: _____

I (We) understand my (our) records may contain information regarding the diagnosis or treatment of HIV/AIDS, sexually transmitted diseases, drug and/or alcohol abuse, mental illness or psychiatric treatment. I give my authorization for these records to be released, with the exception of the following:

☐ HIV/AIDS diagnosis/treatment/testing

☐ Sexually transmitted disease

☐ Drug/Alcohol abuse/treatment/diagnosis

☐ Mental illness or psychiatric diagnosis/treatment

_____ _____
Patient Signature Date

_____ _____
Partner Signature Date