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Delaware Institute for Reproductive Medicine, P.A.
dreams, science, reality

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

I (We) hereby authorize release of my (our) medical records to Jeffrey B. Russell, M.D. at the Delaware Institute for Reproductive Medicine, P.A. 4745 Ogletown-Stanton Road, Suite 111, Newark, Delaware 19713. **Please fax my medical records to (302)738-3508.** This authorization is valid for 12 months from original signature date.

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

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

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