Fertility & Reproductive Endocrinology Specialists (FRES), SC. d.b.a.
The Reproductive Health & Fertility Center (RHFC)
973 Featherstone Road, Suite 100, Rockford, IL 61107
Ph# 815-986-3737 - Fax# 815-986-3748 or 815-986-3734

Authorization for Disclosure of Health Information

Patient name (please print first, middle initial, & last name) | Birth Date | Phone No.

Street Address | City, State, Zip Code

Authorizes disclosure by:

☐ The Reproductive Health & Fertility Center and Rockford Regional Specialty Laboratory

Or by:

Name of Health Care Provider/Plan/Other in possession of health information

Street Address

City, State, Zip

Phone No. | Fax No.

Authorizes disclosure to:

☐ The Reproductive Health & Fertility Center

Or to:

Name of Health Care Provider/Plan/Other requesting health information

Street Address

City, State, Zip

Phone No. | Fax No.

Information to be disclosed: *Identify below the specific information to be disclosed along with relevant dates of service; this information may contain psychiatric, mental health, developmental disabilities, alcohol and/or drug abuse information, history & physical reports, discharge summaries, clinical notes, diagnostic studies, treatment details, and/or infectious test results, including but not limited to ACQUIRED IMMUNE DEFICIENCY SYNDROME (AIDS)/HIV TEST RESULTS, etc:*

Records pertaining to: _____

Approximate dates: _____

Purpose for Disclosure: please provide specific purpose for disclosure of health information:

☐ Transfer or Further Medical Care - Notes: _____

☐ Application for Insurance ☐ Legal Investigation ☐ Disability Determination ☐ Personal Use

Your rights with respect to this authorization: ***Right to inspect or receive a copy of the Health Information to be used or disclosed*** *– I understand that I have the right to inspect or receive a copy of the health information I have authorized to be used or disclosed by this authorization form.* ***Right to receive a copy of this authorization –*** *I understand that if I agree to sign this authorization, which I am not required to do, I must be provided with a signed copy of the form.* ***Right to refuse to sign this authorization –*** *I understand that I am under no obligation to sign this form and that the person(s) and/or organization(s) listed above who I am authorization to use and/or disclose my information may not condition treatment, payment, enrollment in a health plan or eligibility for health care benefits on my decision to sign this authorization.* ***Right to withdraw this authorization –*** *I understand that written notification is necessary to cancel this authorization. I am aware that my withdraw will not be effective as to uses and/or disclosures of my health information that the person(s) and/or organization(s) listed above have already made in reference to this authorization. RHFC will not condition treatment on the completion of this authorization. I understand that once my health information leaves the control of RHFC, it may be further disclosed by the receiving party. I agree that I will not hold RHFC liable for re-disclosures of the health information I have authorized that are made by the recipient named in this Authorization.*

I understand that disclosure of my health information to an outside health care provider and/or health care facility directly from RHFC is of courtesy; disclosure of my health information for any purpose other than for transfer or for further medical care and/or to anyone other than another a healthcare provider and/or health care facility requesting my health information, including but not limited to myself, will require payment due to RHFC.

Expiration Date – this authorization is valid for (5) five years from the date of signature unless it is revoked with your written request.

I have had an opportunity to review and understand the content of this authorization form. By signing this authorization, I am confirming that it accurately reflects my wishes.

Signature of patient/legal representative; _____ Date _____

(If signed by other than patient, identify relationship and authority to do so)