URA
CONCEIVING THE FUTURE

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AUTHORIZATION TO USE &/ OR DISCLOSE PROTECTED HEALTH INFORMATION

I authorize University Reproductive Associates

☐ to **RELEASE** medical records to : ☐ someone else picking up (Please print name below)
☐ to **OBTAIN** medical records from:

_____
Name / Facility

_____
Address

_____
City State Zip Code

_____ _____
Telephone Fax

Type of information to be disclosed consists of:

☐ Complete record ☐ OB letter ☐ Lab results ☐ Radiology results (US/ Mammo/ HSG/ Bone Density)

☐ Operation Report ☐ Pap smear ☐ Cycle sheets ☐ Other:_____

I understand that medical records may contain confidential information such as: (1) HIV related information, (2) Drug and alcohol information, (3) Sexual abuse information, (4) mental health/ illness information. (Patients 14 years of age or older being treated for mental illness or drug and/or alcohol abuse must sign this authorization themselves.)

I understand this authorization may be revoked by me, through written notification to the Privacy Officer at University Reproductive Associates, at any time, except for any action which has already been taken. University Reproductive Associates may not condition treatment on your agreement to sign this authorization.

The information being disclosed is from records whose confidentiality is protected by New Jersey & Federal law through the health Insurance Portability & Privacy Act (HIPPA). NJ law prohibits the receiver of records from making any further disclosure of information unless further disclosure is expressly permitted by the written authorization of the person to whom it pertains or is otherwise permitted by law. A general authorization for the release of information is not sufficient for this purpose.

I hereby release the provider of said records from any legal responsibility or liability in connection with the release of the records indicated and herein. This authorization shall remain in effect and valid for 90 days.

_____ _____
Patient's Full name (please print) Patient's Signature (if minor, signature of parent/guardian)

_____ _____
Patient's Date of Birth Date Relationship to patient

Purpose of use/disclosure:
☐ Moving ☐ PCP ☐ Insurance change ☐ Transfer of care ☐Referral ☐ Changing MD ☐ Personal use

☐ Other: (describe fully) _____

★ **Please allow approx. 2 weeks for processing.** ★ **Copying fee of $1.00 per page will be charged.**

PLEASE SEND THIS FORM BACK TO MEDICALRECORDS@URANJ.COM