!! ITEMS IN RED MUST BE COMPLETED AFTER PRINTING !!

The Center For Reproductive Medicine, PC
(251)438-4200 Fax (251)438-4211

Chart No._____

Medical Records Release and Assignment either by Fax or Copies

I hereby authorize my physician Dr. George T. Koulianos or Dr. George B. Inge to release any information acquired in the course of my examination or treatment by Dr. Koulianos or Dr. Inge to my health insurance carriers, referring physicians, and other physicians or hospitals which might provide services to me while I am receiving services from Dr. George T. Koulianos or Dr. George B. Inge. I understand that this information is either transmitted through FAX transmission or copies made of the original document mailed via US Post Master.

We accept assignment on most insurance carriers, but YOU are responsible for any services not covered by your insurance carrier. You agree to make payments to us for co-pays at the time of service. If you have commercial insurance coverage, we will supply insurance forms for your carrier, but YOU are responsible for services rendered which are not paid by your insurance such as deductibles, co-pays and for services which are deemed necessary by our physicians, but are not covered by your insurance even if your insurance carrier deems the services not necessary. In the event you fail to pay for services rendered, you agree to pay reasonable attorney's fees and all cost of collection including court costs if this matter is referred to an attorney or collection company.

I give my permission to release any and all of my test results to my spouse/partner and or person listed below.

Spouse/Partner _____ Decline INITIAL HERE IF YOU ONLY WANT US TO SPEAK WITH YOU

Parent/Other _____

I also give my permission to be contacted or for a message to be left in regards to my account balances, test results and/or any treatment and care by The Center For Reproductive Medicine.

PLEASE INITIAL: _____ I AGREE _____ I DO NOT AGREE

INITAL ONE OF THESE BOXES REGARDING EMAIL

to communicating via email with physicians, nurses, and other office staff regarding medical, insurance, and billing matters. I understand that while every effort will be made to keep my information secure and private, The Center for Reproductive Medicine cannot make any guarantees in this regard and that there are risks associated with unencrypted email transmissions including but not limited to the possibility of information being intercepted by a third party or improperly accessed during storage or transmission. I also understand that The Center for Reproductive Medicine has no control over the internet service provider that transmits the information.

I have read the above agreement and agree to all.

Name _____ Birth Date _____
PLEASE PRINT

Email Address_____

MAKE SURE TO SIGN THIS FORM HERE Date_____
Signature

Revised 07/22/2014 mlb

The Center for
Reproductive Medicine

The Best Science, Medicine
And Care for Each Family

RECORDS RELEASE

PLEASE FORWARD TO YOUR OB-GYN OR APPROPRIATE PHYSICIAN IMMEDIATELY!

Date: _____

Dear Dr. _____,

Please forward the following records:
HSG results
Infertility progress notes
Infertility Lab results
Infertility Ultrasounds
Operative notes related to infertility evaluation (with videos or pictures, if possible)
Semen Analysis of spouse or partner

I hereby authorize and request you to release the results for procedures listed above to:

George T. Koulianos, M.D. **Phone: 251-438-4200**
George B. Inge, M.D. **Fax: 251-438-4211**

3 Mobile Infirmary Circle
Suite 213
Mobile, Alabama 36607

My appointment date is _____ Time:_____

I state that authorization may be revoked at any time. I also state that the disclosed information may be subject to re-disclose by the recipient.

I understand that this information is either transmitted through FAX transmission or copies made of the original document mailed via US Post Master.

This records release will expire 12 months from date signed.

Patient name: _____
Please print.
Patient signature: _____

Social Security Number: _____

Date of Birth: _____

Witness: _____