THE NEW HOPE CENTER
FOR REPRODUCTIVE MEDICINE
New Hope. New Life. New Beginnings.
A DIVISION OF MID-ATLANTIC WOMEN'S CARE, PLC

AUTHORIZATION FOR RELEASE OF PATIENT MEDICAL INFORMATION

ATTN: ______________________________ PHONE: ______________________________
______________________________ FAX: ______________________________

I HEREBY AUTHORIZE THE ABOVE PARTY TO RELEASE THE FOLLOWING MEDICAL INFORMATION TO:

THE NEW HOPE CENTER FOR REPRODUCTIVE MEDICINE
Robin L. Poe-Zeigler, M.D., F.A.C.O.G.
Christian Perez, M.D., F.A.C.O.G.
448 Viking Drive • Suite 100 • Virginia Beach, VA 23452
PHONE: (757) 496-5370 • FAX: (757) 481-3354

PATIENT NAME: ______________________________ DATE OF BIRTH: ______________________________
SSN: ______________________ PHONE: ______________________ LAST APPT DATE: ______________________
FORMER NAME IF APPLICABLE: ______________________________

THIS INFORMATION SHOULD INCLUDE BUT NOT LIMITED TO THE FOLLOWING:

FEMALE

OPERATIVE NOTES

HSG REPORTS AND FILMS

STIMULATION SHEETS (OVULATION INDUCTION AND IVF)

POST-COITAL RESULTS

HORMONAL STUDIES (FSH, LH, TSH, PRL, ETC.)

DELIVERY NOTES

LAB TEST INCLUDING: CURRENT PAP, ANTISPERM AB'S, RUBELLA, ETC.

OTHER: ANY OTHER RECORDS THAT PERTAIN TO THIS PATIENT'S TREATMENT IN YOUR OFFICE

MALE

SEMEN ANALYSIS

SPERM FUNCTION TESTING RESULTS

INTRA-UTERINE INSEMINATION RESULTS

UROLOGY: OPERATIVE REPORTS

This authorization expires exactly one year from the date which it is signed. The patient has the right to cancel this authorization at any time. Cancellation of this authorization must be submitted in writing. Each New Hope Center patient is provided with a copy of full HIPAA privacy policy guidelines in their new patient packet. If you have any questions and would like an additional copy of the HIPAA guidelines you may request one at any time.

______________________________ ______________________________
PATIENT SIGNATURE (PARENT OR GUARDIAN OF MINOR) DATE

______________________________ ______________________________
WITNESS DATE