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Welcome to IVFMD!

In order to save time at your initial appointment, please complete your **New Patient Forms** prior to arriving at the clinic.

You may bring the completed forms with you to your first appointment, or you may scan and email them to **frontdesk@ivfmd.net.**

If you are unable to keep your appointment, please call the office **48 hours in advance**. Please remember that failure to keep or cancel your appointment will result a **$30.00 charge**. Please help us to serve you better by keeping you scheduled appointments.

We look forward to seeing you soon!

Thank you,

IVFMD
Office Staff

**Irving** | 7501 Las Colinas Blvd., Suite 200A Irving, TX 75063 | Phone: 972-506-9986 | Fax: 972-506-0044
**Arlington** | 600 W Mayfield Rd., Arlington, TX 76014 | Phone: 817-701-1290 | Fax: 817-701-1297
**Grapevine** | 1631 Lancaster Dr., Suite 225, Grapevine, TX 76051 | Phone: 817-310-0031 | Fax: 817-310-0034

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# IVFMD NEW PATIENT MEDICAL QUESTIONNAIRE

Name: _____ Age: _____ Occupation: _____

Couple status: ☐ Legally Married ☐ Common Law ☐ Single ☐ Same Gender

Partner's name: _____ Age: _____ Occupation: _____

Your ethnicity: ☐ Caucasian ☐ Afri-Amer ☐ Hispanic ☐ Asian ☐ Ashkenazi ☐ Other _____

Partner's: ☐ Caucasian ☐ Afri-Amer ☐ Hispanic ☐ Asian ☐ Ashkenazi ☐ Other _____

Name of your OBGYN: _____ Who referred you? ☐ self ☐ friend ☐ PCP ☐ OBGYN

## A. Medical History

1. Medication you are on: _____
2. Allergy: ☐ None known ☐ Iodine ☐ Shellfish ☐ Peanuts
   Drug allergies (list symptoms): _____
3. Do you use: ☐ Tobacco ☐ Alcohol ☐ Drugs How much: _____
4. Date of last Pap: _____ ☐ Not yet ☐ Normal ☐ Abnormal
5. Date of mammogram: _____ ☐ Not yet ☐ Normal ☐ Abnormal
6. Please indicate any significant illness you have had:

☐ Anorexia. Bulimia ☐ Asthma ☐ Rheumatoid arthritis ☐ Crohn's or Ulcerative colitis
☐ Diabetes ☐ Heart disease ☐ Hepatitis ☐ B or ☐ C ☐ Hypertension
☐ Hypothyroidism ☐ Hyperthyroidism ☐ Kidney disease ☐ Lupus
☐ Mitral valve prolapse ☐ Rheumatic fever ☐ Seizure ☐ Stroke
☐ Venous thrombosis ☐ Ulcer (GI) Other _____

## B. Surgical History

Year

1. ☐ Abortion ☐ D&C ☐ Cryosurgery ☐ LEEP/conization _____
2. _____
3. _____
4. _____
5. _____

## C. Menstrual History

1. How often do you have your periods? _____
2. Do you have to shave or wax facial hair every week? _____ ☐ Yes ☐ No
3. Do you have breast discharge? ☐ Left ☐ Right Color: _____ ☐ Yes ☐ No
4. Do you have hot flashes? How often? _____ ☐ Yes ☐ No
5. Do you: ☐ spot 2-3 days before your period? ☐ pass quarter size clots? ☐ Yes ☐ No
6. When was your thyroid hormone last checked? _____
7. Do you have painful cramps with your periods? ☐ Yes ☐ No

## D. Sexual History

1. Do you have pain with intercourse? ☐ Yes ☐ No
2. How often do you have intercourse? _____
3. Have you had 3 or more sexual partners in the past? ☐ Yes ☐ No
4. Have you ever had an abnormal Pap smear? When? _____ ☐ Yes ☐ No
5. Have you had: ☐ PID ☐ Chlamydia ☐ Gonorrhea ☐ Herpes ☐ HPV ☐ Trichomonas ☐ Yes ☐ No
6. Have you ever used: ☐ Birth control pill ☐ IUD ☐ Depo-Provera

## E. Review of System

1. Over the past 2 years have you ☐ gain or ☐ lost weight? _____ lbs ☐ Yes ☐ No
2. Do you exercise? How often? _____ Type? _____ ☐ Yes ☐ No
3. Has your mother reached menopause? At what age? _____ ☐ Yes ☐ No

## F. Pregnancy History

| Year | Is partner the father? | Miscarriage? | Terminated? | Vaginal birth or C-section? | Baby's sex | Complication |
|---|---|---|---|---|---|---|
| | | | | | | |
| | | | | | | |
| | | | | | | |
| | | | | | | |
| | | | | | | |

## G. Previous Fertility Treatment

| Treatment | Year | # Cycle | # IUI | Physician | Outcome |
|---|---|---|---|---|---|
| Clomid | | | | | |
| Femara | | | | | |
| Injectable meds (Bravelle, Follistim, Gonal-f, Menopur) | | | | | |
| Clomid + Injectable | | | | | |
| Femara + Injectable | | | | | |
| In Vitro Fertilization | | | | | |
| Frozen Embryo Transfer | | | | | |

## H. Family Medical History

Who? Please indicate maternal (**M**) or paternal (**P**) side

☐ Cystic fibrosis _____ ☐ Cancer: breast _____
☐ Hemophilia _____ uterus _____
☐ Musc dystrophy _____ ovary _____ colon _____
☐ Sickle cell _____ Other _____
☐ Tay sach _____ ☐ Diabetes _____
☐ Thalassemia _____ ☐ Hypertension _____
☐ Mental disease _____ ☐ Heart attack _____ Stroke _____
Other _____ ☐ Hypothyroid _____ Hyperthyroid _____

## I. Male Partner's History

| | YES | NO |
|---|---|---|
| 1. Has he been credited with any pregnancy (including miscarriage)? # _____ Number of children? _____ Age of youngest _____ | ☐ | ☐ |
| 2. Has he ever had ☐ mumps ☐ radiation therapy ☐ chemotherapy | ☐ | ☐ |
| 3. Does he have ☐ diabetes ☐ hypertension ☐ erectile problem | ☐ | ☐ |
| 4. Does he take testosterone? _____ | ☐ | ☐ |
| 5. Does he take any regular medication? _____ | ☐ | ☐ |
| 6. Did he ever have infection of the prostate? _____ | ☐ | ☐ |
| 7. Has he ever had injury to groin or genitalia? _____ | ☐ | ☐ |
| 8. Did he have ☐ varicocele surgery ☐ testicular surgery ☐ vasectomy reversal? | ☐ | ☐ |
| 9. Does he smoke? How much? _____ | ☐ | ☐ |
| 10. Does he drink alcohol? How much? _____ | ☐ | ☐ |
| 11. Does he use recreational drug? What type? _____ | ☐ | ☐ |

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## GENERAL INFORMATION

Name: _____ _____ _____
First (Nombre) Middle (Inicial) Last (Apellido)

Home Address: _____
Street (Direccion)

City _____ State _____ Zip _____
(Ciudad) (Estado) (Postal)

Telephone Home # _____ Work # _____ Cell # _____
(Casa #) (Trabajo #) (Cellular #)

Birthdate _____ Age _____ SSN # _____
(Fecha de Nacimiento) (Edad) (Seguro Social)

Marital Status ☐ Married ☐ Single ☐ Common Law Occupation _____
(Marital) (Ocupacion)

Employer _____ _____
(Empleador) Address (Direccion)

Insurance Name _____ Insurance ID # _____ Group # _____
(Aseguranza) (Numero de Poliza)

Responsible Party ☐ Self ☐ Spouse ☐ Other _____

Responsible Party's Name _____ Occupation _____

Responsible Party's Employer _____

Responsible Party Employer Address _____

Who referred you ? _____ Primary Care Physician _____
(Quien le recomendo esta oficiana?)

Emergency Contact Person _____ Phone # _____

**INSURANCE AUTHORIZATION**: I hereby authorize **IVFMD & Advanced Reproductive Laboratory (ARL)** to furnish information to my insurance carriers concerning my illness and treatment. I agree that if I fail to notify IVFMD & ARL of insurance change or obtain required referrals or preauthorization for services, I will be responsible for those charges.
**AUTORIZACION DE SEGURO**: Autorizo **IVFMD & Advanced Reproductive Laboratory** que provea informacion medica de mi persona a las companias de seguro necesarias. Convengo que si no notifico ARCC & ARL del cambio del seguro u obtener requirió remisiones o el preauthorization para los servicios, yo seré responsable de esas cargas.

**ASSIGNMENT OF BENEFITS**: I hereby assign **IVFMD & Advanced Reproductive Laboratory** all payments for medical services rendered to myself or my dependents. I understand that I am responsible for any amount not covered by insurance.
**AUTORIZACION DE BENEFICIOS**: Asigno **IVFMD & Advanced Reproductive Laboratory** los beneficios del seguro, por servicios prestados a mi persona o dependientes mios. Entiendo que soy responsable por aquellos gastos no cubiertos por las companias de seguros.

_____ _____
Signature of Authorized Person (Firma de la Persona Autorizada) Date (Fecha)

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## SPOUSE INFORMATION

Spouse's Name: _____ _____ _____
First (Nombre) Middle (Inicial) Last (Apellido)

Home Address: _____
Street (Direccion)

City _____ State _____ Zip _____
(Ciudad) (Estado) (Postal)

Telephone Home # _____ Work # _____ Cell # _____
(Casa #) (Trabajo #) (Cellular #)

Birthdate _____ Age _____ SSN # _____
(Fecha de Nacimiento) (Edad) (Seguro Social)

Occupation _____ Employer _____
(Ocupacion) (Empleador)

Employer's Address _____
Address (Direccion)

Insurance Name _____ Insurance ID # _____ Group # _____
(Aseguranza) (Numero de Poliza)

Responsible Party ☐ Self ☐ Spouse ☐ Other _____

Responsible Party's Name _____ Occupation _____

Responsible Party's Employer _____

Responsible Party Employer Address _____

Who referred you ? _____ Primary Care Physician _____
(Quien le recomendo esta oficiana?)

Emergency Contact Person _____ Phone # _____

**INSURANCE AUTHORIZATION**: I hereby authorize **IVFMD & Advanced Reproductive Laboratory (ARL)** to furnish information to my insurance carriers concerning my illness and treatment. I agree that if I fail to notify IVFMD & ARL of insurance change or obtain required referrals or preauthorization for services, I will be responsible for those charges.
**AUTORIZACION DE SEGURO**: Autorizo **IVFMD & Advanced Reproductive Laboratory** que provea informacion medica de mi persona a las companias de seguro necesarias. Convengo que si no notifico ARCC & ARL del cambio del seguro u obtener requirió remisiones o el preauthorization para los servicios, yo seré responsable de esas cargas.

**ASSIGNMENT OF BENEFITS**: I hereby assign **IVFMD & Advanced Reproductive Laboratory** all payments for medical services rendered to myself or my dependents. I understand that I am responsible for any amount not covered by insurance.
**AUTORIZACION DE BENEFICIOS**: Asigno **IVFMD & Advanced Reproductive Laboratory** los beneficios del seguro, por servicios prestados a mi persona o dependientes mios. Entiendo que soy responsable por aquellos gastos no cubiertos por las companias de seguros.

_____ _____
Signature of Spouse (Firma del Esposo) Date (Fecha)

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# Couples Policy

At IVFMD we are dedicated to helping couples and individuals build their families. We are committed to providing all individuals with a complete, yet cost efficient infertility evaluation. We welcome patients of all backgrounds and beliefs, and respect the personal choices that individuals and couples make in their lives. However, because we have an integral role in bringing new life into this world, we would like to clearly define how we approach patients and their partners regarding the services that we offer to them.

**Married woman:** Legally married - Marriage certificate, share last name. Patient may use her husband's semen for IUIs or IVF. If needed, donor sperm is an option as well.

**Single woman**: Not legally married. Patient may use cryopreserved donor sperm from a bank.

**Common Law**: Couples not legally married but who live together, consider themselves as married and introduce themselves to society as such - Demonstrate official proof of cohabitation for 1 year or more (tax forms, home ownership, joint lease or utility bills) or that you already have a child together. Patients will be treated as couples with a marriage certificate.

**Other**: You do not consider yourself single and do not meet criteria for being married or in a common law relationship. We will gladly provide you with an evaluation. To receive treatment by us, we would like to have a clear definition for the source of the sperm. If you cannot clearly define the relationship with your partner, we will not be able to do ovulation induction or use his sperm in the process. If you find yourself in this situation, you may consider defining your relationship (getting married) or ordering donor sperm (which is clearly defined by the sperm bank as donor sperm). Otherwise we will gladly refer you to other Reproductive Endocrinologists in the community.

Thank you for understanding our Couples Policy. Please let us know if you have any questions or concerns.

I understand and agree to this Couples Policy,

Print Patient Name: _____

Signature of Patient: _____ Date: _____

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# Advance Patient Notice for Use of a Non-Participating Provider or Facility

As a patient you have the right to receive services at a participating facility or by a participating physician or provider in order to obtain full benefits under your health plan.

However, if you are receiving this notice you have chosen to have your service or procedure done at a non-participating facility. We would advise that if you have questions or would like to locate an in network physician, provider or facility to provide the services or procedures, please contact your carrier at the telephone number listed on the back of your card.

**By placing my signature below, I have acknowledged the following:**

1) I am aware that I am using a non-participating facility for my IVF (In-Vitro Fertilization) procedures.

2) I was given the opportunity to contact my carrier before obtaining these services to confirm my benefits for non-network services and to obtain names of participating facilities.

3) I am voluntarily choosing on behalf of myself to receive service or procedure from a non-participating facility. Furthermore, I understand and agree that I am a self-paying patient for my IVF (In Vitro Fertilization) procedure and IVFMD/Advanced Reproductive Lab will not submit my claims to my carrier on my behalf. Upon the completion of my IVF treatment I will be responsible for submitting my claims to my carrier and accept all implications as set forth by my carrier.

Patient Name (print): _____

Patient Signature: _____ Date: _____

IVFMD Staff Signature: _____

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# PREFERRED PHARMACY

**Please fill out the following information:**

Patient Name: _____

DOB: _____

Pharmacy Name: _____

Pharmacy Address: _____

_____

Pharmacy Phone #: _____

**The pharmacy you provide will be used to send all of your prescriptions.**

**Thank You,**

**IVFMD**

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# Notification of Sperm Sample Drop-off Policy

Welcome from the IVF laboratory team! We are committed to providing you state-of-art IVF lab services here.

We encourage you to use our facility to collect sperm samples for tests or procedures. It provides a well-controlled environment to protect sample quality and allows u process the sample in a timely manner.

However, in some special situations when you can't make an on-site collection, you can choose to drop off your sperm sample. Below is our current policy for sample drop-off:

**For IVF/ICSI or IUI sperm:**

We will ONLY accept the sample when it is dropped off by **the male patient (who produced the sperm)**. A photo ID will be checked to match name and date of birth by our receiving lab technician.

**For semen analysis:**

The sperm samples can be dropped off by either the male patient or his partner.

Please talk to your nurses if you are considering dropping off your sperm sample. They will help you to schedule it accordingly. Do not hesitate to let us know if you have any questions.

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IVF Lab

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# FINANCIAL POLICY

Thank you for choosing IVFMD as your health care provider. We are committed to the success of your treatment. The following form is a statement of our Financial Policy, which we require you to read and sign prior to any treatment.

## Insurance

We may accept assignment of insurance benefits upon your first visit. However, we do require that you pay your portion of the bill at the time of service (ie. co-pay, deductible, etc.). We will do everything reasonably required to facilitate the filing of your insurance claim. You need to provide us with correct insurance information along with all other relevant documents (i.e. secondary insurance, change in insurance plan).

Your insurance is a contract between you and your insurance company. Please be aware that your insurance carrier may deny coverage for services that are in our opinion usual, customary, and medically necessary. Your carrier may declare the treatment as not medically necessary and thus not covered. We charge what is usual and customary for our area. Because the bill is your responsibility, should your insurance not pay, you will be billed for the remaining balance.

Under special circumstances, we offer an extended payment plan with prior approval. If your account becomes 90 days delinquent from the last day of service, please understand that your account will be forwarded to a collection agency.

## Missed Appointments

Unless canceled at least **2 business days** in advance, our policy is to charge $30 for any missed appointments, such as, cancellations, rescheduled-appointments, or no-show appointments (subject to extenuating circumstances). Please help us serve you better by keeping scheduled appointments.

## Returned Checks

There will be a $25 service charge for returned checks.

Thank you for understanding our Financial Policy. Please let us know if you have any questions or concerns.

I understand and agree to this Financial Policy,

Print Patient Name: _____

Signature of Patient: _____ Date: _____

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## AFTERHOURS POLICY

Our staff is available to answer calls of an urgent nature before and after office hours. However, we ask that you exercise thoughtfulness in your decision to call, especially if the call concerns instruction for injection of medications. Please do not call to ask about mixing or administration of medications between 5 PM to 8 AM.

Please note that a **$20.00 fee** will be assessed for calls of the following nature made before or after office hours:

- Calling to schedule an appointment.
- Paging the physicians during office hours (instead of calling the office number).
- Calling to refill medications.
- Calling to inquire about insurance issues such as authorization for appointment or medications.
- Calling for test results unless the nurse has left you a message to do so.

The Arlington and Irving offices are open for calls on:

| | |
|---|---|
| Monday and Wednesday | 8:00 am to 6:00 pm |
| Tuesday and Thursday | 8:00 am to 5:00 pm |
| Friday | 8:00 am to 2:00 pm |
| Saturday | 8:00 am until 12:00 pm (noon) |

Monday through Thursday a lunch break is taken from 1:00 pm until 2:00 pm

We appreciate your understanding and cooperation.

Patient's Signature: _____

Date: _____

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# NOTIFICATION OF PRIVACY POLICIES

THIS NOTICE DESCRIBES HOW INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW CAREFULLY.

## Introduction

At IVFMD we are committed to treating you and using protected health information about you responsibly. This Notice of Health Information Practices describes the personal information we collect, and how and when we use or disclose that information. It also describes your rights as they relate to your protected health information. This notice applies to all protected health information as defined by federal regulations.

## Understanding Your Health Record/Information

Each time you visit IVFMD, a record of your visit is made. Typically, this record contains your symptoms, examination and test results, diagnoses, treatment, and a plan for future care or treatment. This information, often referred to as your medical record, serves as a:

- Basis for planning your care and treatment,
- Means of communication among the many health professionals who contribute to your care,
- Legal document describing the care you received,
- Means by which you or a third-party payer can verify that services billed are actually provided,
- A tool in educating health professionals,
- A source of data for medical research,
- A source of information for public health officials charged with improving the health of this state and the nation,
- A source of data for our planning and marketing,
- A tool with which we can assess and continually work to improve the care we render and the outcomes we achieve.

Understanding what is in your record and how your health information is used helps you to: ensure its accuracy, better understand who, when, where, and why others may access your health information, and make more informed decisions when authorizing disclosure to others.

## Your Health Information Rights

Although your health record is the physical property of IVFMD, the information belongs to you. You have the right to:

Obtain a paper copy of this notice of information practices upon request,
Inspect and copy your health record as provided for in 45 CFR 164.524,
Amend your health record as provided fro in 45 CFR 164.528
Obtain an accounting of disclosures of your health information as provided for in 45 CFR 164.528
Request communications of your health information by alternative means or at alternative locations,
Request a restriction on certain uses and disclosures of your information as provided by 45 CFR 164.522, and
Revoke your authorization to use or disclose health information except to the extent that action has already been taken.

**Our Responsibilities**

IVFMD is required to:

- Maintain the privacy of your health information
- Provide you with this notice as to our legal duties and privacy practices with respect to information we collect and maintain for you,
- Abide by terms of this notice,
- Notify you if we are unable to agree to a requested restriction, and
- Accommodate reasonable requests you may have to communicate health information by alternative means or at alternative locations.

We reserve the right to change our practices and to make the new provisions effective for all protected health information we maintain. Should our information practices change, we will mail a revised notice to the address you have supplied us, or if you agree, we will email the revised notice to you.

**For More Information or to Report a Problem**

You may contact our Privacy Officer, Mark Gollner, at 972-506-9986.

If you believe your privacy has been violated, you can file a complaint with the practice's Privacy Officer or with the Office for Civil Rights, US Department of Health and Human Services. There will be no retaliation for filing a complaint. The address for the OCR is:

Office for Civil Rights
U.S. Department of Health and Human Services
200 Independence Ave, SW
Room 509F, HHH Building
Washington, D.C. 20201

**Examples of Disclosures for Treatment, Payment, and Health Operation**

*We will use your health information for treatment*

**For example**: Information obtained by a nurse, physician, or other members of your health care team will be recorded in your record and used to determine the course of treatment that should work best for you. Your physician will document in your record his or her expectations of the members of your health care team, who will then record the actions they took and their observations. In that way, the physician will know how you respond to the treatment.

We will also provide your physician or a subsequent health care provider with copies of various reports that should assist him or her in treating you once you are discharged from this practice.

*We will use your health information for payment*

**For example**: A bill may be sent to you or a third-party payer. The information on or accompanying the bill may include information that identifies you, as well as your diagnosis, procedures, and supplies used.

*We will use your health information for regular health operations*.

**For example**: Members of the medical staff, the risk or quality improvement manager, or members of the quality improvement team may use information in your health record to assess the care and outcomes in your case and others like it. This information will then be used in an effort to continually improve the quality and effectiveness of the healthcare and service we provide.

*Business associates*: There are some services provided in our organization through contacts with business associates. Examples include physician services in the emergency department, anesthesiology, radiology, and certain laboratory tests. When these services are contracted, we may disclose your health information to our business associates so that they can perform the job we have asked them to do and bill your third-party payer for services rendered. To protect your health information, however, we require the business associate to appropriately safeguard your information.
*Notification*: We may use or disclose information to notify or assist in notifying a family member, personal representative, or another person responsible for your care, your location, and general condition.

*Communication with family*: Health professionals, using their best judgment, may disclose to a family member, other relative, close personal friend or any other person you identify, health information relevant to that person's involvement in your care or payment related to your care.

*Research*: We may disclose information to researchers when their research has been approved by an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your health information.

*Marketing*: We may contact you to provide appointment reminders by mail, answering machine messages, or your voicemail, or to provide information about treatment alternatives or other health- related benefits and services that may be of interest to you.

*Public Health*: We may disclose your health information to public health or legal authorities charged with preventing or controlling disease, injury, or disability as required by law.

*Worker compensation*: We may disclose health information to the extent authorized by and to the extent necessary to comply with laws relating to workers compensation.

*Law enforcement:* We may disclose health information for law enforcement purposes as required by law or in response to a valid subpoena.

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## ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY NOTICE – FEMALE PATIENT

I have been presented with a copy of **Notice of Privacy Policies** detailing how my information may be used and disclosed as permitted under federal and state law. I understand the contents of the Notice, and I request the following person(s) to obtain information about my care including laboratory results:

☐ Spouse Name: _____

☐ Other Name(s): _____

I have the right to change these restrictions and have the most recent authorization used.

**Patient's Signature:** _____

**Date:** _____

If not signed by the patient, please indicate your relationship to the patient (e.g. spouse).

**Relationship:** _____

**Witnessed by** (employee): _____

**Privacy officer/designee signature:** _____

**Restriction accepted:** ☐ **Yes** ☐ **No**

**Patient notified of acceptance/denial:** ☐ **Yes** ☐ **No**

**For office use only:**

If patient refuses to sign, indicate your attempt to obtain a signature below.

☐ Patient refused to sign this Acknowledgment.

Reason: _____

_____

Employee Name: _____ Date: _____ Time: _____

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## ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY NOTICE – PATIENT'S PARTNER

I have been presented with a copy of **Notice of Privacy Policies** detailing how my information may be used and disclosed as permitted under federal and state law. I understand the contents of the Notice, and I request the following person(s) to obtain information about my care including laboratory results:

☐ Spouse Name: _____

☐ Other Name(s): _____

I have the right to change these restrictions and have the most recent authorization used.

**Partner's Signature:** _____

**Date:** _____

If not signed by the patient's partner, please indicate your relationship to the patient (e.g. mother).

**Relationship:** _____

**Witnessed by** (employee): _____

**Privacy officer/designee signature:** _____

**Restriction accepted:** ☐ **Yes** ☐ **No**

**Patient notified of acceptance/denial:** ☐ **Yes** ☐ **No**

**For office use only:**

If patient's partner refuses to sign, indicate your attempt to obtain a signature below.

☐ Patient refused to sign this Acknowledgment.

Reason: _____

_____

Employee Name: _____ Date: _____ Time: _____

**Irving** | 7501 Las Colinas Blvd., Suite 200A Irving, TX 75063 | Phone: 972-506-9986 | Fax: 972-506-0044
**Arlington** | 600 W Mayfield Rd., Arlington, TX 76014 | Phone: 817-701-1290 | Fax: 817-701-1297
**Grapevine** | 1631 Lancaster Dr., Suite 225, Grapevine, TX 76051 | Phone: 817-310-0031 | Fax: 817-310-0034

ivfmd

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## AUTHORIZATION FOR DISCLOSURE OF CONFIDENTIAL INFORMATION

Patient's Name: _____ Chart #: _____

Address: _____

Date of Birth: _____

**I hereby authorize and request:**

Doctor's Name:_____

Address: _____

Phone: _____ Fax: _____

To release the following information to:

**IVFMD, P.A.**
**7501 LAS COLINAS BLVD., SUITE 200A**
**IRVING, TX 75063**

- Check All That May be Released:

☐ Infertility notes & relevant studies only

☐ Other, please specify: _____

- Purpose of Disclosure

☐ Infertility evaluation

☐ Other: _____

This authorization shall be valid for 120 days from the date of signature. The patient can revoke this authorization in writing any time prior to the expiration date.

Patient's Signature: _____ Date: _____

Witness: _____

ivfmd

www.ivfmd.net

# MEDICAL RECORD RELEASE AUTHORIZATION

Patient's Name: _____D.O.B_____

Address: _____

City: _____State: _____ Zip: _____

Before signing authorization for the release of my medical record, I acknowledge the following:

1. I understand that there will be a charge for labor and material cost in photocopying my medical record ($25 for the first 20 pages and $0.50 for each additional page). I will be notified of the total amount and will pay this fee before my record is released.
2. I understand that my medical record will be mailed within one week after payment is received.

I have read and agreed with the above conditions and authorize:

**IVFMD, P.A.**
**SY Q. LE M.D.**

to release the following information to:

Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone: _____ Fax: _____

Check all that may be released: ☐ Entire record

☐ Infertility notes & relevant studies only

☐ Other, please specify _____

This authorization shall be valid for 120 days from the date of signature. The patient can revoke this authorization in writing any time prior to the expiration date.

Patient's Signature: _____ Date:_____

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# MEDICAL RECORD RELEASE AUTHORIZATION

Patient's Name: _____D.O.B_____

Address: _____

City: _____State: _____ Zip: _____

I authorize: **IVFMD, P.A.**

to fax my medical record to:

Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone: _____ Fax: _____

Check all that may be released: ☐ Entire record

☐ Infertility notes & relevant studies only

☐ Other, please specify _____

This authorization shall be valid for 120 days from the date of signature. The patient can revoke this authorization in writing any time prior to the expiration date.

Patient's Signature: _____ Date:_____

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