

**Patient, please send this form directly to the physician who has your medical records so that he or she may send them to Dr. Tippet prior to your appointment.**



Center for Fertility & Gynecology

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Infertility  
Reproductive Endocrinology  
Gynecology

Paul D. Tippet, M.D.

### AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

I hereby authorize \_\_\_\_\_ to release a complete copy of the medical records of:

Patient's Name: \_\_\_\_\_

Maiden Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

SSN/MR#: \_\_\_\_\_

to The Center for Fertility & Gynecology at the address shown on this form. The records are requested to allow for my continuing medical care, and your prompt attention to this matter is appreciated.

SPECIFIC RECORDS OR TESTS REQUESTED: \_\_\_\_\_

I understand the following:

- That the release of my health record(s) will be for the purpose stated on this form.
- That the health record(s) released by the facility/person authorized above may possibly be re-disclosed by the facility/person that receives the record(s) and therefore (1) its staff/employees have no responsibility or liability as a result of the re-disclosure and (2) such information would no longer be protected by the Privacy Rule.
- That this Authorization is in effect for a period of 90 days from the date of signature, unless a specific time frame is documented; however, no time frame specified shall go beyond one year from the date of signature.
- That I have the right to revoke this authorization form at any time by sending a written request to the entity where the authorization was provided.
- That my decision to revoke the authorization does not apply to any release of my health record(s) that may have taken place prior to the date of my request to revoke the authorization.
- That my decision to revoke the authorization may result in my insurance company not being able to pay for my medical care and I may be liable to payment of the claim.
- That I am entitled to a copy of this completed authorization form.

\_\_\_\_\_  
Signature of Patient

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Witness

\_\_\_\_\_  
Date