CENTER FOR FERTILITY & GYNECOLOGY

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

Dear Patient,

Please send this form directly to your last physician who will forward a copy of your medical records to Dr. Tippet to allow for continuation of care. Please do this as soon as possible otherwise your records may not be in our office at the time of your appointment.

Paul D. Tippet, MD
6400 Brooktree Court Suite 100
Wexford, PA 15090
Phone 724-933-3310 Fax 724-933-3320

I hereby authorize____ to release a complete copy of my medical records to Dr. Paul D. Tippet.

Patient Information

Current Name:____________________________Prior Name____________________________

Date of Birth______________________________SSN______________________________

I understand the following

1. That the release of my heath record(s) is the stated purpose of this form.
2. That my health record(s) will be sent to Dr. Tippet's office where they will be received and viewed by the by the staff who are authorized and trained for this task.
3. That this Authorization is in effect for a period of 90 days from the data of signature.
4. I have the right to revoke this authorization at any time by sending a written request to the entity where the authorization was provided.
5. If I decide to revoke this authorization, this decision will not apply to records that have already been sent to the Center for Fertility & Gynecology.
6. If I decide to revoke or refuse the release of my records to my insurance company that they may not pay for my care/treatment.
7. I understand that I am entitled to a copy of this form.

Patient ____Date____________

Wittness____Date____________