Embryo Donation International

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Release of Records From EDI

Patient Identifying & Contact Information (Please print clearly):

Name: _____ Date of Birth: _____/_____/_____

Address: _____ Home Phone: (____) _____-_____

City: _____ Cell Phone: (____) _____-_____

State: _____ Zip: _____ Work Phone: (____) _____-_____

Country _____ E-mail: _____

Please ❒Mail or ❒Fax My EDI Records TO (Please print clearly):

Facility/Name: _____

Address: _____ Work Phone: (____) _____-_____

City: _____ Fax: (____) _____-_____

State: _____ Zip: _____ Country Code: _____

Country _____ Contact: _____

Types of Medical Records To Be Sent (Check Those That Apply):

❒Entire Record Which Includes, But Is Not Necessarily Limited To all Listed Below (or check separately):

❒ History & Physical Exam	❒ Surgical Reports	❒ Outside Laboratory Results
❒ Progress Notes	❒ Pathology Reports	❒ Internal Lab Reports
❒ Summary of Care	❒ Discharge Summary	❒ Ultrasound Reports
❒ Sexually Transmitted Disease Results Including Acquired Immunodeficiency Syndrome (AIDS) and/or Human Immunodeficiency Virus (HIV)		
❒ Behavioral or Mental Health Services and/or Treatment for Alcohol and/or Drug Abuse		
❒ Records for other physicians: Names: _____		

By signing this request, I release and hold harmless EDI and all employees for all liability, including negligence, that may arise from complying with this authorization. EDI is authorized by Florida law to charge me for duplication costs incurred in connection with the copying my medical records. Since discussion regarding both partners is common in the medical record, if applicable, we request a separate request for record release from you partner.

The information included with this cover sheet may be privileged, confidential and protected from disclosure as outlined by the Federal HIPAA Privacy Rules 45 CFR. If the reader is not the intended recipient, you are hereby notified that any reading, nation, distribution, copying or other use of this material is strictly prohibited. If you receive this information in error, please notify the sender immediately by the contact numbers listed below.

This information if being disclosed for continued medical care. I understand that I have the right to revoke this authorization in writing. I understand that revocation will not apply to information that has already be release by my authorization. I hereby authorize the disclosure of my medical information from EDI. Unless otherwise specified below, this authorization will expire six months from the date of signing.

Signature: _____ Date: _____/____/____ Request Expires: _____/____/____

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