Male Fertility Specialists
Fertility Center of California

Authorization to Send Medical Records FROM Male Fertility Specialists and / or Fertility Center of California

This consent authorizes the healthcare provider named below to release confidential medical information and records. Note: Information and medical records regarding treatment to minors, HIV, psychiatric/mental health conditions have special rules that apply and require specific information.

I hereby authorize Male Fertility Specialist and or Fertility Center of California and specifically Martin D Bastuba, MD or Cindy Jansen, CNP to release copies or information regarding my medical history, illness or injury, consultation, prescriptions, treatment, diagnosis or prognosis including X-rays, ultrasounds, correspondence, and/or medical records by means of mail, email, fax or other electronic methods to:

Physician Name: ________________________________
Address - Street/Suite ________________________________
City/State/Zip ________________________________

This authorization is
- ☐ Unlimited: (all records including substance abuse, mental health, HIV, pregnancy) ______ initials
OR
- ☐ Medical records EXCEPT the following medical information:

Drug/Alcohol/Substance abuse __________ initials
Psychiatric/Mental health __________ initials
STD / HIV __________ initials
Pregnancy information under 21 __________ initials

Duration: This authorization shall be effective immediately and will remain in effect until ___/___/___.

Restrictions: I hereby agree to the further transfer of my medical information for continuum of care issues or when required by law. A photograph, facsimile or email of this authorization shall be effective and valid as the original. I have been advised of my right to receive a copy of this authorization.

Reason for transfer: ∆ continuing medical care ∆ for my records ∆ attorney request
∆ other ____

____________________________ Please print name

____________________________ Signature

____/____/____ Date

___/___/___ Date of Birth

XXX-XX- ___________ Social Security Number

____________________________ Print Witness Name

____________________________ Witness Signature

02/05/16