



**Male Fertility Specialists
Fertility Center of California**

**Authorization to Send Medical Records TO
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 _____ (physician/group)

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:

Male Fertility Specialists or Fertility Specialists of California
6699 Alvarado Road Suite #2208
San Diego, CA 92120
619-836-3520 or patients@malefertility.md

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.

Please print name

Signature

___/___/___
Date

___/___/___
Date of Birth

XXX-XX-_____
Social Security Number

Print Witness Name

Witness Signature

10/14/15

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