Fertility Wellness Institute
NeeOo W. Chin MD

Authorization for Release of Medical Information

Date of Request: _____
Patient Name: _____ Patient #: _____
Date of Birth: _____ LAST 4 OF SSN: _____
Address: _____ City, State, Zip: _____

I hereby authorize _____ to release the following from my medical records:
____ Only information pertaining to infertility

*****PLEASE NOTE: Our office only needs medical information pertaining to infertility such as diagnostic workup and medical and/or surgical treatment.**

Release the above information to:

Dr. Neeoo W. Chin, MD
6396 Thornberry Ct.
Suite 710
Mason, OH 45040

Phone:(513) 326.4300
Fax:(513) 326-4306

This authorization is valid for 90 days from the date of signature.
It may be revoked in writing by the undersigned at any time prior to the release of the information from the disclosing party.
The requester may not lawfully further use or disclose the health information unless another authorization is obtained, unless disclosure is specifically required or permitted by law.
The patient may inspect or copy the protected health information used or disclosed pursuant to authorization and may refuse to sign the authorization. The patient shall receive a copy of this authorization upon request.

_____
Patient's Signature Date

_____
Spouse's Signature (blood work and semen analysis) Date