REPRODUCTIVE PARTNERS
UCSD REGIONAL FERTILITY CENTER

Reproductive Partners Medical Group, Inc.

Authorization for Release of Protected Health Information

Patient: ________________________________ Birthdate:___/___/___SSN:_______________

Spouse/Partner:_________________________ Birthdate:___/___/___SSN:_______________

Address:____

Telephone:(H)______________________(W)____

To: ____

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I authorize the release of all information about my care and treatment covering the dates of health care service from _______________(date) to _______________(date) to be sent to:

Reproductive Partners Medical Group, Inc.
9850 Genesee Avenue, Suite 800
La Jolla, CA 92037
Phone: 858-552-9177
Fax: 858-552-9188

Additionally, I specifically authorize the release of information pertaining to HIV (human immunodeficiency virus and AIDS(acquired immunodeficiency syndrome testing).

____
Signature of Patient

____
Date

____
Signature of Spouse/Partner

____
Date

Release of records to RPMG
dr H 1/24/08