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**ALL REQUESTS MUST BE SENT TO:  
 RECORDREQUEST@NHFC.COM**

## AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION (PHI)

Request Release of Medical Records to:  Self  Partner\*

**\*If requesting for Partner, Partner  
 Signature will be required on the bottom\***

**Please read and complete all fields below before signing.**

Patient Last Name: \_\_\_\_\_ Patient First Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_ Email: \_\_\_\_\_

**Please read and complete all fields below before signing.**

**Female Comprehensive History (ALL)**

From Dates \_\_\_\_\_ to \_\_\_\_\_

**Lab Reports**

- Hormone Level Reports
- Infectious Disease Reports
- Pathology Reports
- PDG Test Reports

**Surgical Records**

- Egg Retrieval
- Embryo Transfer
- Hysteroscopy/D&C
- Sonogram images (current 3 months)

**Pre-Surgical**

- Genetics Lab
- Pap Smear

**Stim Sheets (most current 12 months)**

**Include:** (Indicate by Initialing)  
 \_\_\_\_\_ **Alcohol/Drug Treatment**  
 \_\_\_\_\_ **Mental Health Information**  
 \_\_\_\_\_ **HIV-Related Information**

Patient Last Name: \_\_\_\_\_ Patient First Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

**Male Comprehensive History (ALL)**

From Dates \_\_\_\_\_ to \_\_\_\_\_

**IUI Reports**

- Infectious Disease Reports
- Male Screening lab
- Male Genetics Lab

**Sperm Freezing Reports**

**Semen Analysis Reports**

**Method of Release: CHOOSE ONE ONLY**

Pick Up     Email     Mail (use address above, **\$25.00 mailing fee required**)

Release to Affiliated Physician ONLY

Provider Name: \_\_\_\_\_ ATTN: \_\_\_\_\_

Address: \_\_\_\_\_ Fax: \_\_\_\_\_ Phone: \_\_\_\_\_

The processing time may take up to 14 days, an expedited 72 hour request subject to \$100.00 additional fee. The price is \$0.50 per page. **All mailed documents are subject to a \$25 mailing fee. Photo ID is required for pickup.**

**\*Payment must be made in full prior to release of medical records\***

**I hereby certify that all items on this form have been completed and my questions have been answered.**

Patient name \_\_\_\_\_ Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Partner name (Print): \_\_\_\_\_ Partner Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Internal use only: Received by: \_\_\_\_\_ Date: \_\_\_\_\_ Initials: \_\_\_\_\_ Chart #: \_\_\_\_\_

Processed by: \_\_\_\_\_ Date: \_\_\_\_\_ Initials: \_\_\_\_\_