The Center for Reproductive Health.

2410 Patterson Street Suite 401 ♦ Nashville ♦ TN ♦ 37203 ♦Voice: (615) 321-8899 ♦ FAX: (615) 321-8877

Dear Patient:

Welcome to the Center for Reproductive Health (CRH). We look forward to meeting with you at your initial consultation which will last approximately 2 hours. Please plan to arrive 15 minutes prior to your appointment, allowing ample time for parking and locating the office. Every effort will be made to start your consultation at the scheduled time.

To ensure efficient use of your time here, we ask that you and your partner take a few moments to fill out the enclosed patient information sheets. You will need to request copies of your medical records from the physicians who have been treating you and your partner. Please include the following test results, if they have been performed, and bring them with you at the time of your visit.

- Copies of any abdominal and/or pelvic operative reports;
- Recent semen analysis report and any other pertinent male infertility diagnostic tests;
- Written hysterosalpingogram (HSG) report (please bring the actual films to your initial consultation);
- Stimulation sheets from previous IVF or IUI treatment cycles;
- Please complete the Request for Medical Records and mail or fax them to your OB-GYN, PCP, or other infertility doctors. Those physicians will send copies of your medical records to our practice to facilitate your medical care and avoid duplication of tests or procedures already performed in your past medical care.

If your partner is available, we would encourage him/her to come. We ask that you not bring children or infants to your appointment.

You will receive a call from our office to confirm your appointment several days prior to the consultation.

We ask that if you need to cancel or reschedule your appointment that you give us 48 hours' notice. Please refer to the Patient Accounts and Insurance Policy for additional information. Additionally, if your insurance requires that you obtain a PCP referral to be seen at our practice, please be sure to have that at your initial visit.

Sincerely,

The CRH Team

The Center for Reproductive Health.

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I hereby authorize ______________________________to release the medical record of ____________________________________, To: ***the Center of Reproductive Health***, 2410 Patterson Street, Suite 401, Nashville, TN 37203, Phone#: 615-321-8899 for the following purpose: ____ For treatment dates: ____

(Specify dates – this line MUST BE completed)

SELECTION PORTIONS

_____ H&P
_____ Consultation
_____ Lab
_____ Imaging/Radiology
_____ Progress Notes
_____ Operative Report
_____ Andrology Results
_____ Entire Record
_____ Other: ____________
____

I authorize the release of the information specified above with the exception of:

_____ Substance abuse, if any
_____ AIDS/HIV, if any

_____ Psychological or psychiatric conditions, if any

**** This authorization expires 60 days from the date signed below and covers only treatment for the dates specified above.**

I understand that the Center is given ten (10) working days to process my request for access to my information. I further understand that my rights are limited to any information in my "designated record set" as defined in Section 164.501 pf the Code of Federal Regulations. By signing below, I acknowledge and agree to the above conditions.

I, the undersigned, have read the above and authorize the staff of the disclosing facility named to disclose such information as herein contained. I understand that this consent may be withdrawn by me at any time to the extent that action has been taken in reliance upon it. Unless another date is specified, this consent shall be valid for sixty (60) days from the date it is signed. I understand that redisclosure of this information to a party other than the one designated above is forbidden without additional authorization on my part. This facility is released and discharged on any liability and the undersigned will hold the facility harmless, for complying with this "Authorization for Release of Medical Information."

__________ ____________________________________ _________________________
Date Signature of Patient Signature of Witness

____ __________________________
Records Copied By: (Please Print) Date Copied

Records: Mailed Picked Up Date: ___________________