AUTHORIZATION REGARDING THE USE AND RELEASE OF HEALTHCARE INFORMATION
(Please allow 7-10 business days for medical records to be copied)

I, _____, Date of Birth _____, consent and authorize:

Provider/Facility Name: _____
Address: _____
City, State, Zip: _____
Phone Number: _____
Fax Number: _____
(Please list your Provider or with Contact Information)

To Provide: Blue Sky Fertility
6675 Holmes Rd, Suite 680
Kansas City, MO 64131
Phone: 816-301-5506 Fax: 816-214-8617

Scope:

□ All information regarding assessment, diagnosis, and treatment of the following condition(s), concern, or disease (specify): _____

□ All information regarding care received by patient between the dates of
Starting Date: _____ *and* *Ending Date:* _____

□ Other Information (specify):
_____
_____

Some information is covered by additional protection(s) and requires specific authorization. To authorize release or discussion of the following type(s) of information, you must initial and date each item. If an item is not initialed and dated, the information, if such information exists, cannot be released or discussed.

Initial	Date		From	To
_____	_____	Alcohol or Drug Use/Abuse Treatment	_____	_____
_____	_____	Mental Health Treatment	_____	_____
_____	_____	HIV Status or Treatment	_____	_____

This authorization to release medical records will expire one year from the date below (today's date) unless indicated otherwise by you:

□ When information Is received □ In six (6) months
□ In three Years □ On Date _____

I understand that my information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by Privacy Regulations. A photostatic copy of this authorization shall be considered effective and valid as the original.

Signature of Patient: _____ Today's Date: _____
Patient Contact Phone Number:_____

Ryan M. Riggs. MD
Board-Certified Fertility Specialist
www.blueskyfertility.com