Sending Medical Records to CCRM from Other Physicians

Following this page is a medical record release form to use for requesting your records from your previous physician. Once your previous physician's office receives this form, they will send your records directly to CCRM.

Medical record releases can take many weeks. To insure CCRM receives your records in time, please submit these forms to your doctor as soon as possible. Records must be received no less than 3 business days before your appointment.

Please be sure to thoroughly complete the form, including the date of your upcoming CCRM appointment at the top and your signature at the bottom, then send the completed form to your previous physician's office.

If you have records with more than one physician, you will need to send a separate completed form to each of your past physicians. If you have a spouse or partner, he/she will need to complete a separate release form as well for each physician's office they were seen at.

CCRM FERTILITY COLORADO

Authorization to Release Medical Records to CCRM

Patient Name (printed):_____ Date of Birth: _____

Previous Name (if applicable):_____SSN: _____

CCRM appointment date_____(Please have records arrive no less than one week before thisdate!)

I hereby authorize_____to release the following medicalrecords:

☐ **Female:**

Most Recent Labs: TSH, Free T4, CBC, Chem Panel (CMP), Prolactin, Vitamin D, Varicella titer (quantitative), Rubella titer (quantitative), ABO/Rh (blood type), Antibody screen (indirect coombs), Estradiol, FSH, LH, AMH, Karyotype, Genetic Screening (Genevue, Goodstart, Counysl)

Most Recent Exams: HSG (including images and report), Annual exam (including breast exam), Pap smear (including cytology report), Mammogram (including radiology report)

Previous Treatment: Embryology reports from any IVF cycles in the last two years, Stimulation records from IVF cycles in the last two years (hormones, doses, ultrasounds), Operative reports from GYN surgeries (laparoscopy, operative hysteroscopy, D&C, etc.)

☐ **Male:**

Karyotype, Genetic Screening (Genevue, Goodstart, Counysl), Male hormone testing, Urologist records (including the consultation notes), Semen analysis (including morphology, ASAB, chromatin, culture, etc.)

☐ **Additional:** _____

To: ☐ Colorado Center for Reproductive Medicine
Lone Tree Office
10290 RidgeGate Circle, Lone Tree, CO 80124
Fax Number: (303) 788-8310 Phone Number: (303) 788-8300

☐ Colorado Center for Reproductive Medicine
Denver (Rose) Office
4600 Hale Parkway, Suite 490, Denver, CO 80220
Fax Number: (303) 355-2099 Phone Number: (303) 355-2555

☐ Colorado Center for Reproductive Medicine
Louisville (Avista) Office
80 Health Park Drive, Medical Plaza II, Suite 240, Louisville, CO 80027
Fax Number: (303) 665-0740 Phone Number: (303) 665-0150

This authorization shall expire upon: ☐ Fulfillment of this request **OR** ☐ Date: _____

My Rights: I may revoke this authorization in writing. If I do, it will not affect any actions already taken by the above-named practice based upon this authorization. I may not be able to revoke this authorization if its purpose was to obtain insurance. Once the office discloses health information, the person or organization that receives it may re-disclose it. Privacy laws may no longer protect it.

_____ _____
Patient or Legally-Authorized Individual Signature *Date*

_____ _____
Printed Name (If signed on behalf of the patient) *Relationship (parent, guardian, etc.)*