Family Fertility Center

95 Highland Avenue, Suite 100   Telephone (610) 868-8600
Bethlehem, PA 18017   Fax (610)868-8700

Request for Access to Records

Notice to Patient: You may use this form to request to inspect or copy information maintained about you. This type of request is described in our Practice's Notice of Privacy Practices.

Patient Name		DOB or SSN	

Description of Records Requested:
(*Please describe the records or types of records requested. Please also let us know how far back in time you want access to records.*)

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Scope of Request:

        [   ] Inspect the requested records.
        [   ] Obtain a copy of the requested records.
        [   ] Inspect and copy the requested records.

Requested Records to be Released to:

Name	**H. Christina Lee, M.D., Family Fertility Center**
Address	**95 Highland Avenue, Suite #100, Bethlehem, PA 18017**
Telephone number	**(610) 868-8600** **Fax (610) 868-8700**

Fee for Copying Requested Records
Our Practice may charge a reasonable fee for the cost of copying your requested records. We may also charge you for postage if you ask us to mail your requested records.

Patient Authorization
By my signature below, I understand that this information is confidential and will only be released as specified in this authorization and according to both Federal HIPAA Privacy Rules (45 C.F.R Parts 160 and 164) and Pennsylvania State Law (Act 26 of 1998).
In addition, it is specifically understood that the records being requested may contain psychotherapy note, and/or alcohol and substance abuse information, and/or HIV/AIDS information. As such, I hereby authorize Family Fertility Center to release or disclose all my medical records or other information regarding my treatment, hospitalization, and/or outpatient care, including mental health care, drug abuse, alcoholism, Acquired Immuno-Deficiency Syndrome (AIDS), or test for or infection with Human Immunodeficiency Virus (HIV).

_____
Print Name of Patient   Signature of patient   Date

For Personal Representative of the Patient (if applicable)
I hereby certify that I have the legal authority under applicable law to make this request on behalf of the patient identified above.

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Print Name of personal   Signature of personal   Date   Relationship to patient
Representative   representative   (or other authority)

Contact Person
Please contact our Practice's Privacy Official if you have any questions relating to requests to inspect or copy records.