

CONSENT TO RELEASE INFORMATION

**Mid-Iowa
FERTILITY, P.C.**

Patient Name _____ Date of Birth _____

I, the undersigned, hereby authorize Mid-Iowa Fertility, P.C. to release medical information to following:

Name _____ Relationship: _____

Name _____ Relationship: _____

I understand that I may revoke this consent at anytime by sending written notice to this office.

Please list in order of preference, **only** the numbers where we can reach you **or** leave a message. A phone number listed tells us we may use this number to contact you and leave a message.

1 _____ this is my _____ number.

2 _____ this is my _____ number.

3 _____ this is my _____ number.

Only our Administrative Staff, including the Financial Specialist, Receptionist and Billing Department uses email to correspond with patients. Please list your email address so we may respond to your billing and administrative questions:

_____ @ _____ .com

I authorize Mid-Iowa Fertility, P.C. to release to the insurance carrier(s) the information I have provided in order to facilitate claim payment. I permit a copy of this authorization to be used in place of the original signature and request that payment of claims be made directly to MID-IOWA FERTILITY, P.C. I understand that I am financially responsible for all services received, regardless of insurance payment or denial.

Signature of patient or legal guardian

Today's date