



# Damien Fertility Partners

## RECORDS RELEASE POLICY

Please be advised that the following is Damien Fertility Partner's policy regarding the release of Medical Records. I (We) am/are requesting a personal copy of the medical record.

We will only release records generated by Damien Fertility Partners. Only written requests will be accepted. All records will be reviewed by Dr. Miguel Damien or Dr. Emily Holden. Records that are required for immediate medical care may be retrieved by front office personnel. Records will be sent directly to the patient's home or may be picked up in our Shrewsbury office. Records requests will be completed within thirty (30) days for charts located in our Shrewsbury office and sixty (60) days for charts located in our off premise storage facility. All records will be copied by front office personnel. Records may be faxed/sent to other physicians who are participating in the patient's care upon direct request from this other physician's office and with confirmation by the patient. The patient's personal request of records will be provided for a fee of \$1.00 per page up to a maximum of \$100.00.

You may request to inspect your medical records. Please call our Shrewsbury office, 732-758-6511, to arrange a mutually convenient time.

A summary or explanation of the requested information can be written by your physician, for an additional fee.

I understand that I do not have the right to access: 1) Psychotherapy notes; 2) Information compiled in reasonable anticipation of, or for use in a civil, criminal, or administrative action or proceeding; and 3) Protected health information that is: (a) Subject to the Clinical Laboratory Improvements Amendments of 1988, 42 USC 263A, to the extent the provision of access to you would be prohibited by law; or (b) Exempt from the Clinical Laboratory Improvements Amendments of 1988, pursuant to 42 CFR 493.3(a)(2).

I (We) have read the above-referenced Records Release Policy and accept and agree to the terms and conditions stated therein.

\_\_\_\_\_  
Patient's Signature                  Patient's Name (Please Print)                  Date

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Patient's Signature                  Patient's Name (Please Print)                  Date

**\*\*\*\*Please fax back to: 732-758-1048\*\*\*\***