



# Embryo Donation International

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## Requesting Records To Send To EDI

### Patient Identifying & Contact Information (Please print clearly):

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_  
Address: \_\_\_\_\_ Home Phone: (\_\_\_\_) \_\_\_\_-\_\_\_\_  
City: \_\_\_\_\_ Cell Phone: (\_\_\_\_) \_\_\_\_-\_\_\_\_  
State: \_\_\_\_\_ Zip: \_\_\_\_\_ Work Phone: (\_\_\_\_) \_\_\_\_-\_\_\_\_  
Country \_\_\_\_\_ E-mail: \_\_\_\_\_

### Requesting Medical Records Sent To EDI Via Mail or Fax *From:*

Facility/Name: \_\_\_\_\_  
Address: \_\_\_\_\_ Work Phone: (\_\_\_\_) \_\_\_\_-\_\_\_\_  
City: \_\_\_\_\_ Fax: (\_\_\_\_) \_\_\_\_-\_\_\_\_  
State: \_\_\_\_\_ Zip: \_\_\_\_\_ Country Code: \_\_\_\_\_  
Country \_\_\_\_\_ Contact: \_\_\_\_\_

### Types of Medical Records To Be Sent (Check Those That Apply):

Entire Record Which Includes, But Is Not Necessarily Limited To all Listed Below (or check separately):

<input type="checkbox"/> History & Physical Exam	<input type="checkbox"/> Surgical Reports	<input type="checkbox"/> Outside Laboratory Results
<input type="checkbox"/> Progress Notes	<input type="checkbox"/> Pathology Reports	<input type="checkbox"/> Internal Lab Reports
<input type="checkbox"/> Summary of Care	<input type="checkbox"/> Discharge Summary	<input type="checkbox"/> Ultrasound Reports
<input type="checkbox"/> Sexually Transmitted Disease Results Including Acquired Immunodeficiency Syndrome (AIDS) and/or Human Immunodeficiency Virus (HIV)		
<input type="checkbox"/> Behavioral or Mental Health Services and/or Treatment for Alcohol and/or Drug Abuse		
<input type="checkbox"/> Records for other physicians: Names: _____		

### Please Send My Medical Records To:

Embryo Donation International, P.L  
12611 World Plaza Lane, Building 53  
Fort Myers, Florida 33907, USA  
Fax: (239) 275-5914

Please **DO NOT** send this release to EDI!

Please **DO** send this release to your  
previous medical provider.

*We request that all records be available for review at  
least two weeks prior to your scheduled discussion.*

The information included with this cover sheet may be privileged, confidential and protected from disclosure as outlined by the Federal HIPAA Privacy Rules 45 CFR. If the reader is not the intended recipient, you are hereby notified that any reading, nation, distribution, copying or other use of this material is strictly prohibited. If you receive this information in error, please notify the sender immediately by the contact numbers listed below. This information if being disclosed for continued medical care. I understand that I have the right to revoke this authorization in writing. I understand that revocation will not apply to information that has already be release by my authorization. I hereby authorize the disclosure of my medical information from EDI. Unless otherwise specified below, this authorization will expire six months from the date of signing.

Signature: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ Request Expires: \_\_\_\_/\_\_\_\_/\_\_\_\_

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