AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION (FROM CFRM)

PATIENT NAME: _____ DOB: _____ SS#: _____

PARTNER NAME: _____ DOB: _____ SS#: _____

I hereby authorize The Centre for Reproductive Medicine to "disclose", release and provide a copy, summary, or narrative of my protected health information (otherwise known as my medical records) as indicated by the checkmark(s) below:

☐The complete record

☐Records of care from _____ to _____ only

☐Records of care concerning the following condition(s)

_____

☐Other:

_____

To the following health care provider, person or entity:

Name: _____
Address: _____
_____
Phone: _____ Fax: _____

The reason or purpose for this disclosure of information is as follows: _____

1. I understand that I may revoke this authorization at any time by notifying the providing organization in writing, and that this revocation will be effective on the date notified except to the extent action has already been taken in reliance upon the authorization. I understand that treatment, payment, enrollment, or eligibility for benefits may not be conditioned upon me signing this authorization.

2. I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer protected by Federal privacy regulations.

3. I understand that all requests will be processed within thirty (30) business days after receipt of a proper written request.

4. I understand that in compliance with Texas statute and according to rules set forth by the Texas State Board of Medical Examiners, a fee of $25.00 for the first 20 pages and $0.50 per page thereafter plus postage will be charged for record requests.

Patient Signature: _____ Date: _____
(Or person legally authorized to consent on patient's behalf.)

Partner Signature: _____ Date: _____

An expiration date or event: _____

FOR OFFICE USE ONLY

Date Received: _____ Initials: _____

Date Completed: _____ Initials: _____

5/2012