

**The Centre for Reproductive Medicine, P.A.
Janelle Dorsett, M.D.**

**AUTHORIZATION TO DISCLOSE
PROTECTED HEALTH INFORMATION
(TO 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:

**Dr. Janelle Dorsett
3405 22nd Street, Suite 300
Lubbock, Texas 79410
Ph. (806) 788-1212 Fax (806) 788-1253**

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

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: _____