



AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

COMPLETE ALL SECTIONS, DATE, AND SIGN

I. I, _____, hereby voluntarily authorize the disclosure of information from my health record.

II. The information is to be disclosed by:	And is to be provided to:
NAME OF FACILITY	NAME OF PERSON/ORGANIZATION/FACILITY
ADDRESS	ADDRESS
CITY/STATE	CITY/STATE

III. The purpose or need for this disclosure is:

- Further Medical Care
 Attorney
 School
 Research
 Personal Use
 Insurance
 Disability
 Other (Specify) _____

IV. The information to be disclosed from my health record: (check appropriate box(es))

- Only information related to (specify) _____
 Only the period of events from _____ to _____
 Other (specify) (CHS, Billing, etc.) _____
 Entire Record

If you would like any of the following sensitive information disclosed, check the applicable box(es) below:

- Alcohol/Drug Abuse Treatment/Referral
 HIV/AIDS-related Treatment
 Sexually Transmitted Diseases
 Mental Health (Other than Psychotherapy Notes)
 Psychotherapy Notes ONLY (by checking this box, I am waiving any psychotherapist-patient privilege)

V. I understand that I may revoke this authorization in writing submitted at any time to IVFCMG, except to the extent that action has been taken in reliance on this authorization. If this authorization was obtained as a condition of obtaining insurance coverage or a policy of insurance, other law may provide the insurer with the right to contest a claim under the policy. If this authorization has not been revoked, it will terminate one year from the date of my signature unless a different expiration date or *expiration event* is stated. _____
 (Specify new date)

I understand that IVFCMG will not condition treatment or eligibility for care on my providing this authorization except if such care is:
 (1) Research related or (2) provided solely for the purpose of creating Protected Health Information for disclosure to a third party.

I understand that information disclosed by this authorization, except for Alcohol and Drug Abuse as defined in 42 CFR Part 2, may be subject to re-disclosure by the recipient and may no longer be protected by the Health Insurance Portability and Accountability Act Privacy Rule [45 CFR Part 164], and the Privacy Act of 1974 [5 USC 552a].

SIGNATURE OF PATIENT OR PERSONAL REPRESENTATIVE (State relationship to patient)	DATE
SIGNATURE OF WITNESS (If signature of patient is a thumbprint or mark)	DATE

Patient Information

 Patient Name (Last, First, MI)

 Patient Address

 Date of Birth

 Record Number (Account number)