AMERICAN FERTILITY MEDICAL CENTER

2 Hughes, Suite 175, Irvine, CA 92618

AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION

Completion of this document authorizes the disclosure and use of health information about you. Failure to provide all information requested may invalidate this authorization.

Name of patient _____ **Date of birth** _____

USE AND DISCLOSURE OF HEALTH INFORMATION

I hereby authorize: **American Fertility Medical Center** to release to: (_____Persons/Organizations authorized to receive the information) _____(Address — street, city, state, zip code)

The following information:

☐ All health information pertaining to my medical history, mental or physical condition and treatment received; OR

☐ Only the following records or types of health information (including any dates):

_____

☐ I specifically authorize release of the following information (check as appropriate):

- ☐ Labs results _____(initial)
- ☐ All physical, occupational and rehab requests, consultations and progress notes _____(initial)

PURPOSE

Purpose of requested use or disclosure: ☐ Patient request; OR ☐ Other:

_____

EXPIRATION

This authorization expires on (date): _____

MY RIGHTS

- I may refuse to sign this authorization. My refusal will not affect my ability to obtain treatment or payment or eligibility for benefits.
- I may inspect or obtain a copy of the health information that I am being asked to allow the use or disclosure of.
- I may revoke this authorization at any time, but I must do so in writing and submit it to the following address: _____.

My revocation will take effect upon receipt, except to the extent that others have acted in reliance upon this authorization.

- I have a right to receive a copy of this authorization.
- Information disclosed pursuant to this authorization could be redisclosed by the recipient. Such redisclosure is in some cases not prohibited by California law and may no longer be protected by federal confidentiality law (HIPAA). However, California law prohibits the person receiving my health information from making further disclosure of it unless another authorization for such disclosure is obtained from me or unless such disclosure is specifically required or permitted by law.

SIGNATURE

Signature of patient _____ Date _____

NOTES FOR PROVIDERS THAT USE THIS FORM:

- If the purpose of the authorization is to use the information for marketing by a third party that remunerates the provider, a statement to this effect must be included in this authorization form.
- If the purpose of the authorization is for the sale of protected health information (PHI), this form must state whether the PHI can be further exchanged for remuneration by the initial recipient.
- A provider that discloses health information pursuant to an authorization must communicate any limitation contained in the authorization to the recipient [Civil Code Section 56.14]. The required notification may be accomplished by giving the recipient a copy of the authorization form.