FertilityAnswers™
Helping couples build families.

HIPAA AUTHORIZATION FOR RELEASE OF INFORMATION

As required by HIPAA (Health Information Portability and Accountability Act) of 1996, Fertility Answers, LLC may not use or disclose your health information except as provided in our Notice of Privacy Policy without your authorization. Your signature on this form indicates that you are giving permission for the use and discloser described herein. You may revoke this authorization at any time by signing and dating the revocation section on your copy of this form and returning it to this office.

PATIENT NAME: **ID#**:
DATE OF BIRTH: **SS#**:
ADDRESS:

I hereby authorize Fertility Answers to release information from my medical record as indicated below to:

NAME: _____ _____

PH#: _____ **FAX#:** _____

ADDRESS: _____

CITY: _____ **STATE:** _____**ZIP:** _____

Information to be released:	**Dates:**	**Purpose:**
☐ History / Physical Exam	_____	_____
☐ Progress Notes	_____	_____
☐ Lab Reports	_____	_____
☐ X-Ray / Ultrasound Reports	_____	_____
☐ Other: _____	_____	_____

1. I understand that I may revoke this authorization at any time by notifying Fertility Answers in writing, and it will be effective on the date notified except to the extent action has already been taken in reliance upon it.
2. I understand that information used or disclosed pursuant to this authorization may be subject to disclosure by the recipient and no longer be protected by Federal privacy regulations.
3. I understand that if I am being requested to release information by Fertility Answers for a certain purpose,
    a. By authorizing this release of information, my health care and payment for my health care will not be affected if I do not sign this form.
    b. I understand that I may see and copy the information described on this form if I ask for it, and I will get a copy of this form after I sign it.
    c. I understand that in compliance with Louisiana statue, I will pay a fee of $_____. There is no charge for medical records if copies are sent to a facility for ongoing care or follow-up treatment.

PRINT PATIENT NAME _____ DATE: _____

SIGNATURE OF PATIENT: _____

SIGNATURE OF PARENT / LEGAL GUARDIAN: _____