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 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 disclosure 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 _____

DATE OF BIRTH _____ SS# _____ ACCOUNT _____

ADDRESS _____

CITY _____ STATE _____ ZIP _____DAY PHONE _____

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

NAME **Fertility Answers - Lafayette**
ADDRESS **206 East Farrel Road**
CITY **Lafayette** STATE **LA** ZIP **70508** FAX **337-989-8766**

INFORMATION TO BE RELEASED:	**DATES:**
☐ HISTORY AND PHYSICAL EXAM	_____
☐ PROGRESS NOTES	_____
☐ LAB REPORTS	_____
☐ X-RAY AND U/S REPORTS	_____
☐ OTHER: _____	_____

PURPOSE OF DISCLOSURE:

☐ LEGAL	☐ CHANGING PHYSICIANS	☐ CONTINUING CARE
☐ SCHOOL	☐ CONSULTATION/SECOND OPINION	☐ INSURANCE PURPOSE
☐ RESEARCH	☐ 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 redisclosure 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 the purpose of:

   _____

   _____

   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.

_____ _____
PRINT PATIENT NAME DATE

_____ _____
SIGNATURE OF PATIENT SIGNATURE OF PARENT/LEGAL GUARDIAN

_____
WITNESS