FertilityAnswers®
Helping couples build families.

HIPAA AUTHORIZATION FOR RELEASE OF INFORMATION

HIPAA Privacy Authorization Form **Authorization for Use or Disclosure of Protected Health Information (Required by the Health Insurance Portability and Accountability Act, 45 C.F.R. Parts 160 and 164)

1. Authorization:

I authorize _____ (healthcare provider) to use and disclose the protected health information described to:

NAME: **Fertility Answers**
ADDRESS: **500 Rue de la Vie, Ste. 510**
CITY: **Baton Rouge** STATE: **LA** ZIP: **70817** FAX: **225-922-3730**

2. Effective period:

This authorization for release of information covers the period of healthcare **ONE YEAR** from today's date including:

HISTORY AND PHYSICIAN EXAM	LAB REPORTS	HSG REPORTS
X-RAY AND U/S REPORTS	SEMEN ANALYSIS	OP REPORTS

PLEASE DO NOT SEND ENTIRE PATIENT CHART

3. Extent of Authorization:

a. □ I authorize the release of my health records (including records relating to mental healthcare, communicable diseases, HIV or AIDS, and treatment of alcohol or drug abuse).

OR

b. □ I authorize the release of my health record with the exception of the following information:

- □ Mental health records
- □ Communicable diseases (including HIV and AIDS)
- □ Alcohol/drug abuse treatment
- □ Other (please specify): _____

4. This medical information may be used by the person I authorize to receive this information for medical treatment or consultation, billing or claims payment, or other purposes as I may direct.
5. This authorization shall be in force and effect until _____ (date or event), at which time this authorization expires.
6. I understand that I have the right to revoke this authorization, in writing, at any time. I understand that a revocation is not effective to the extent that any person or entity has already acted in reliance on my authorization or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.
7. I understand that my treatment, payment, enrollment, or eligibility for benefits will not be conditioned on whether I sign this authorization.
8. I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

_____ _____ _____
Signature of patient or personal representative **Date** **Patient DOB**

_____
Printed name of patient or personal representative and his or her relationship to patient