Fertility & Reproductive Endocrinology Specialists (FRES) d.b.a.
The Reproductive Health & Fertility Center (RHFC)

Consent for Disclosure of Patient Health Information (PHI) – HIPAA

Patient Name _____ Maiden Name _____
Please print (First Name, Middle Initial, Last Name)

DOB _____ Social Security No.# _____-_____-_____ Home Ph# (_____)_____ Cell Ph# (_____) _____

I, the above patient, am providing consent for the use and disclosure of individually identifiable health information relating to me, which is called "Protected Health Information" under the federal regulation known as the HIPAA Privacy Rule, as described below:

If you deem a necessary part of your medical care to be disclosed, please indicate the Individual(s) to whom you are consenting information to be disclosed (please initial and fill in the blank space):

Partner/Spouse _____ _____
(Last Name, First Name, Middle Initial) Date of Birth

Other Individuals _____ _____ _____
Or outside agency (Last Name, First Name, Middle Initial) Date of Birth Relationship

_____ _____ _____
(Last Name, First Name, Middle Initial) Date of Birth Relationship

_____ _____ _____
(Last Name, First Name, Middle Initial) Date of Birth Relationship

I hereby authorize FRES to communicate with me via the following:

Telephone □ Accept □ Decline Voicemail □ Accept □ Decline Email □ Accept □ Decline

Unless otherwise specified, information that you are consenting to be disclosed at the request of the individual or individual(s) listed above may include but are not limited to the following:

- *Financial details* which includes and may not be limited charges, payment, insurance, and account status
- *Medical information* which includes and may not be limited to treatment & clinic notes, correspondence, test results, and prescriptions

Please specify below any specific limitations for disclosure of information):

_____

This consent will automatically expire in three (3) years from the last date of visit.
I have read and understand the following statements about my rights:

- My consent to the Individual(s) who receives my medical/financial information is not my medical/insurance provider covered by the HIPAA Privacy Rule, my released information could be re-disclosed by that/those Individual(s). Thus, I will no longer be protected by federal or state law and will not hold the REPRODUCTIVE HEALTH & FERTILITY CENTER liable for disclosure.
- I may revoke this Consent at any time by notifying the Privacy Officer of THE REPRODUCTIVE HEALTH AND FERTILITY CENTER (RHFC) in writing. I understand that if I choose to revoke this Consent, I should consult RHFC'S Notice of Privacy Practices regarding my revocation rights.
- I may decline to sign this Consent, and this will in no way affect my ability to receive my health care benefits, treatment, payment, enrollment in a health plan or eligibility for benefits.

_____ _____
Signature of Patient or Patient's Representative *Date*

For Patient Representatives:

Printed Name: _____ Relationship to Patient: _____