ArkLaTex Fertility and Reproductive Medicine
A Tri-State Leader in Proactive & Innovative Fertility Care

AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

_____________________________________ _____________________________________
Printed Patient Name Previous Names, if applicable

_____________________________________ _____________________________________
Date of Birth Daytime Telephone Number

SEND INFORMATION TO: (please be specific)
Provider Name/Organization: ____
Address: ____
____
Phone #______________________________ Fax#__________________________________

INFORMATION TO BE RELEASED FROM: (please be specific)
Provider Name/Organization: ____
Address: ____
____
Phone #______________________________ Fax#__________________________________

PURPOSE OF DISCLOSURE: Transfer of Care, Self, Specialist, Other______ (must complete)

INFORMATION TO BE DISCLOSED:
Medical Records from last two years_______
Summary Health Information_______________ Dates of Service: ___________________
Complete Designated Record Set__________________
Other______________________

If the patient is unable to sign, please indicate such and the authority to act of the person who is signing for the patient. This form must be dated within 90 days of receipt, and may be revoked at any time, providing the information has not already been disclosed. Please see our Notice of Privacy Practices for instructions as to how to revoke this authorization. We will not condition treatment on the completion of the authorization. Also, please be aware that once we disclose this information per your instructions the information is subject to re-disclosure and may no longer be protected by HIPAA of 1996. I acknowledge that I have received a copy of the Notice of Privacy Practices _______Initials

____________________ ____________________________________ ______________________________
Date **Signature of Patient or Representative** **Relationship to Patient**

DISCLOSURES REQUIRING SPECIAL CONSENT:
My signature below specifically authorizes the release of healthcare information relating to the testing, diagnosis, or treatment for:
HIV/AIDS Virus______________________ Mental health/Psychiatric Disorders______________
Sexually Transmitted Diseases______________ Drug, Alcohol abuse/treatment__________________

____________________ ____________________________________ ______________________________
Date Signature of Patient or Representative Relationship to Patient

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For Facility Use:
Date Received: _________________________ **Date Information Released:** ___________________
Person/Department Sending Records: ____

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