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INFERTILITY & IVF ASSOCIATES

Authorization for Disclosure of Health Information

Please note: There is a charge of $0.75 per page which must be paid in advance.
We require seven days advance notice to fill medical record requests

This form authorizes the "Provider": **Infertility and IVF Associates** to disclose the following specific health information: **All billing / medical information**

to the following "Recipient" : _____

(Name)

_____

(Address)

This authorization is granted for the following purpose (s): If I am not available
(required please specify)

This authorization is valid until: _____ / _____/ _____
(Unless otherwise stated, authorization expires 6 months from the date of authorized signature)

At any time, this authorization may be revoked by the undersigned individual by submitting a written notice of revocation to the "provider". However, any revocation shall not apply to the extent that the "Provider" has taken action in reliance on this authorization. This information disclosed pursuant to this authorization may be disclosed again by the "recipient" and, if so, may no longer be protected by the "provider" or "Recipient" privacy practices or federal privacy regulations.

By signing my name below, I hereby acknowledge that I have read and fully understand this form. I understand that medical treatment, payment, enrollment in a health plan and eligibility for benefits may not be conditioned in my signing this authorization. I acknowledge that I may refuse to sign this authorization and that I am signing this authorization voluntarily.

_____ _____
Name of Individual (print) Signature of Individual

Date Signed _____ Date of Birth _____

OR…if authorization is given by the following Personal Representative:

_____ Date Signed _____
Signature of Personal Representative
(e.g Attorney-in-fact, Guardian)