



Texas Fertility Center

*Thomas Vaughn, M.D. • *Kaylen M. Silverberg, M.D. • *Lisa Hansard, M.D.
*Natalie Burger, M.D. • *Summer James, M.D. • *Anthony Propst, M.D. • Erika Munch

*Board Certified in Reproductive Endocrinology and Infertility
Board Certified in Obstetrics and Gynecology

AUTHORIZATION FOR RELEASE OF CONFIDENTIAL INFORMATION

PATIENT /PARTNER NAME: Last First MI DOB SSN

ADDRESS: CITY: STATE: ZIP:

DAY PHONE:

- 1. I understand Texas Fertility Center ("TFC") is authorized by me to use or disclose my Protected Health Information for a purpose (described in this document) other than treatment, payment, or health care operations.
2. I understand that this authorization will expire one (1) year from the date I have signed this form.
3. I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer protected by Federal privacy regulations.
5. I have a right to revoke this authorization in writing, except to the extent that action has been taken in reliance on this authorization.

I specifically authorize Texas Fertility Center (TFC) to release my Protected Health Information to the recipient listed below:

NAME OF PERSON:

ADDRESS: CITY: STATE: ZIP:

PHONE: FAX: Email:

Appointment date (if applicable):

INFORMATION TO BE DISCLOSED:

For Time Period: from to

- All health information
History and physical exam
Lab reports
X-ray reports
Ultrasound Reports
Summary Sheets (IVF/FSH)
Other:
Progress notes
Pap smear
Op/Pathology Reports
Semen Analysis (partner must sign)

I specifically authorize the release of information relating to:
Substance abuse (including alcohol/drug abuse)*
Mental health (other than psychotherapy notes) and Developmental Disability Treatment:
Genetic information (including, but not limited, to Genetic Test Results)
IDS/HIV related information
Donor egg, donor sperm, donor embryo, surrogacy, or gestational carrier
X

PURPOSE OF DISCLOSURE: Medical Care Insurance Other:

ELECTRONIC DISCLOSURE: I do do not authorize this information to be disclosed electronically.

Signature of Patient Date OR Parent/Legal Guardian/Authorized Person Date

This form allows for verbal or written communication with the designated recipient listed above. All fields on this form must be completed to process your request.