Texas Fertility Center

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

AUTHORIZATION FOR RELEASE OF CONFIDENTIAL INFORMATION
(Records Release Request)

PATIENT NAME:_____ DOB_____ SSN_____
Last First MI

ADDRESS:_____ CITY:_____ STATE: _____ ZIP: _____ 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. I have read this authorization and understand what information will be used or disclosed, who may use and disclose the information, and the recipient(s) of that information. I understand that treatment, payment, enrollment, or eligibility for benefits may not be conditioned upon me signing this authorization.
2. I understand that this authorization will expire 180 days after I have signed this form. After this date, TFC can no longer use or disclose my Protected Health Information for the below purposes without first obtaining a new authorization 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.
4. I understand that in compliance with HIPAA and applicable Texas law, a fee may accompany this request. The fee will not exceed $25.00 for the first 20 pages and $0.50 per page thereafter plus postage will be charged for record requests. ***All requests will be processed within 15 business days after receipt of a proper request.***
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. In order for the revocation of this authorization to be effective, TFC must receive the revocation in writing, and the revocation must include: (My name and address, the effective date of this authorization, and the recipients of the Protected Health Information according to this authorization, my desire to revoke this authorization, and the date of the revocation, and my signature.) TFC will accept written revocations of this authorization via: (1) Certified U.S. mail or by (2) Facsimile at this number: (512)451-0977 ALL revocations must be sent to TFC's Privacy Officer and are not effective until received.

I specifically authorize *(include full name and address)* _____
to release my ***Protected Health Information to the recipient listed below:***

NAME OF PERSON/FACILITY:_____

ADDRESS:_____ CITY: _____ STATE: _____ ZIP: _____

PHONE:_____ FAX:_____ Email:_____ Appointment date (if applicable):_____

INFORMATION TO BE DISCLOSED: ***Please disclose only what is requested***

For time: from _____ to _____

- Lab
- HSG and/or MRI of Pelvis
- Ultrasound Reports
- Infertility Summary Sheets (IVF/FSH)
- All Embryology Reports
- Op/Pathology Reports
- Semen Analysis (partner must sign)
- Other: _____

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.

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

_____ _____
Description of Representative's Authority to act for Patient Date

To process your request, ALL fields on this form must be completed.

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