FERTILITY FIRST
reproductive endocrine services

Springs Medical Center
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AUTHORIZATION FORM FOR THE USE AND/OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

This authorization, if signed, will authorize *Fertility First* to use **and/or** disclose certain protected health information that is in the practice's possession about

Patient: _____ DOB: _____ Last Four SS#: _____

I hereby authorize the use **and/or** disclosure of my protected health information as described below:

	Date(s) of service
__ All	_____
__ History & Physical Examination	_____
__ Progress Note	_____
__ Test Results	_____
__ Consultation Reports	_____
__ Operative Report	_____
__ Photos, videotapes, ultrasound or other images	_____
__Other_____	_____

1. I understand that this information may include information relating to Acquired Immunodeficiency Syndrome (AIDS) or Human Immunodeficiency Virus (HIV) infection, treatment for drug or alcohol abuse, or mental or behavioral health or psychiatric care.

2. I authorize Dr. Johanna S. Archer to receive **or** provide the information above from **or** give to:
   Name:_____
   Address: _____
   City, State, Zip:_____
   Phone:_____ FAX: _____

4. The protected health information being used and/or disclosed under this authorization is for continuing care.

5. I understand that if my protected health information is disclosed to someone who is not required to comply with the federal privacy regulations, then such information may be re-disclosed and would no longer be protected.

6. I understand that I have the right to revoke this authorization, in writing, at any time by sending such written notification to *Fertility First*. I also understand that my request is not effective for actions already completed.

7. Unless otherwise revoked, I understand that this authorization will expire 180 days from the date of this form or on the following date: _____.

8. I understand that I do not have to sign this authorization as a condition of being treated by *Fertility First* and I certify that I have received a copy of this authorization.

_____ _____
Signature (Patient or Patient's Representative) Date

_____
Printed name of patient's representative given authority to act for patient and relationship to patient