Southwest Fertility Center

Consent for Disclosure of Patient Health Information (PHI) - HIPAA

Patient Name_____ **Maiden Name**_____
Please print (Last Name, First Name, Middle Initial)

DOB_____ **Social Security #**_____-_____-_____ **Home Ph#**(____)_____ **Cell Ph#** (____)_____

I, the above patient, am providing consent for the use and disclosure of individually identifiable health information relating to me, which is called "Protested Health Information" under the federal regulation known as the HIPAA Privacy Rule, as described below:

If you deem a necessary part of your medical care to be disclosed, please indicate the individual(s) to whom you are consenting information to be disclosed (please initial and fill in the blank space):

Partner/Spouse _____ _____ _____
Initial (Last Name, First Name, Middle Initial) Date of Birth

Other Individuals _____ _____ _____ _____
or outside agency Initial (Last Name, First Name, Middle Initial) Date of Birth Relationship

_____ _____ _____ _____
Initial (Last Name, First Name, Middle Initial) Date of Birth Relationship

I CONSENT FOR SWFC TO LEAVE A DETAILED PHONE MESSAGE ON THE FOLLOWING NUMBER:_(_____)_____

I CONSENT FOR SWFC TO EMAIL ME DETAILED INFORMATION AT: _____

Unless otherwise specified, information that you are consenting to be disclosed at the request of the individual(s) listed above may include but are not limited to the following:

- ***Financial details*** which includes and may not be limited to charges, payment, insurance and account status
- ***Medical information*** which includes and may not be limited to treatment & clinic notes, correspondence, test results, and prescriptions

Please specify below any specific limitations for disclosure of information:

_____

_____

This consent will automatically expire in three (3) years from the last date of visit.

I have read and understand the following statements about my rights:

- My consent to the individual(s) who receives my medical/financial information is not my medical/insurance provider covered by the HIPAA Privacy Rule, my released information could be re-disclosed by that/those individuals(s). Thus, I will no longer be protected by federal or state law and will not hold Southwest Fertility Center liable for disclosure.
- I may revoke this Consent at any time by notifying the Privacy Officer of Southwest Fertility Center (SWFC) in writing. I understand that if I choose to revoke this Consent, I should consult SWFC'S Notice of Privacy Practices regarding my revocation rights.
- I may decline to sign this Consent, and this will in no way affect my ability to receive my health care benefits, treatment, payment, enrollment in a health plan or eligibility for benefits.

_____ _____
Signature of Patient or Patient's Representative **Date**

For Patient Representative:

Printed Name _____

Relationship to Patient _____