Laurel Fertility Care
GROWING DREAMS TOGETHER

Laurel Fertility Care
1700 California St Suite 570
San Francisco, CA 94109

www.LaurelFertility.com
t: 415.673.9199
f: 415.673.8796

AUTHORIZATION FOR USE OF DISCLOSURE OF PROTECTED HEALTH INFORMATION

I authorize the Medical Provider listed below to disclose specified medical records to the Recipient listed below. The Medical Provider shall not condition treatment, payment, enrollment, or eligibility for benefits on the submission of this authorization.

Medical Provider:	
Address:	
Phone:	
Fax:	

Recipient Name:	
Address:	
Phone:	
Fax:	

Patient Name:	
DOB:	
Address:	
Phone:	
Fax:	

Health Information Requested (check all that apply)	
ALL medical records	
Radiology/Imaging	
Laboratory Results	
PGT-A Results Only	
*******Check here if you DO NOT want to know the sex of the embryo**	
HIV Test Results ****NOTE: Records may include information relating to HIV or AIDS, however, results of HIV tests will not be disclosed unless specifically requested here****	

I understand that:
This authorization may be revoked upon written request, but any revocation will not apply to information disclosed before receipt of the written request.

A copy of this Authorization is valid as the original. I have the right to receive a copy of this authorization.

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Once requested health information is disclosed, any disclosure of the information by the recipient may no longer be protected under the Federal Health Insurance Portability and Accountability Act of 1996 (HIPAA).

Patient Signature: _____

Printed Name: _____

Date: _____

****If not signed by the patient, please indicate relationship to the patient (check one, if applicable):**

	Parent or guardian of a minor patient who could not consent to health care
	Guardian or conservator of an incompetent patient (provide documentation)
	Beneficiary or personal representative of deceased patient (provide documentation)