Patient Mentor Program Authorization Requirement

Authorization to Release Protected Health Information

I authorize my physician and/or administrative and clinical staff to use and disclose the following Protected Health Information:

YOUR FIRST NAME, CONTACT PHONE NUMBER OF YOUR CHOICE, E-MAIL ADDRESS, DIAGNOSIS AND YOUR AGE

Your protected health information will be disclosed to **patients who are interested in becoming a mentee in the program and wish to ask you to share your experiences and develop an emotional support relationship with you while they are receiving infertility treatment.**

This authorization shall be in force and effect until **the below named patient requests in writing his/her desire to dissolve the relationship with the intent to discontinue the mentoring program involvement** at which time this authorization to disclose this protected health information expires.

I understand that I have the right to revoke this authorization, in writing, at any time by sending such written notification to the program director at : 5245 E Fletcher Ave Suite 1 Tampa, FL 33617.

I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

The Reproductive Medicine Group will not condition my treatment, payment, enrollment in a health plan or eligibility for benefits (if applicable) on whether I provide this authorization for the requested use or disclosure.

I understand that I have the right to:

Inspect or copy the protected health information to be used or disclosed as permitted under federal law(or state law to the extent the state law provides greater access rights.)

☐ Refuse to sign this authorization.

___________________________________ ____________

Print Name of Patient Date

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Signature of Patient

Patient Account #_____________________

Patient Mentor Program
Confidentiality Agreement

This program is a resource offered to patients that is strictly voluntary. No patient is required to participate in the program.

Both Mentor and Mentee agree that all information shared between the two parties will be kept in the strictest of confidence. No information learned through the program is to be shared with a third party.

All Mentees have been advised that the Mentors are current or past patients that have agreed to share their time and experience. These individuals have not received any training or counseling concerning the program from The Reproductive Medicine Group.

If at any time, the Mentor or Mentee want to dissolve the relationship, either party will contact the program director and notify of intent to discontinue the mentoring program involvement of the one specific relationship.

______________________________________ ______________________
Mentee Name Date

____
Mentee Signature

______________________________________ ______________________
Mentor Name Date

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Mentor Signature