PATIENT RELEASE TO DISCLOSE TREATMENT/RESULTS

To ensure The Reproductive Medicine Group protects the security and integrity of your Protected Health Information (PHI) against any unauthorized uses or disclosures, you must give written consent for our practice to disclose your personal information. **This includes release of information about you to your spouse/partner.**

Please list below who you allow us to discuss and/or release your Protected Health Information, such as Plan of Treatment, any diagnostic test results, and/or billing information. This disclosure includes, verbal, written, or electronic communication.

☐ You may verbally discuss my Protected Health Information with the following:

Name of Authorized Receiver	**Relationship to Patient**
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Name of Authorized Receiver	**Relationship to Patient**

Under HIPAA Guidelines and per the Notice of Privacy Practices of The Reproductive Medicine Group, you have the right to request a restriction in the disclosure of your Protected Health Information.

☐ **I restrict the following information from being disclosed:**

_____

_____

_____

By signing below:

1. I understand that I authorize the above named person(s) disclosure of my Protected Health Information. I understand that I have a right to revoke this authorization at any time by submitting a request.
2. I further understand I reserve the right to file a complaint with the Privacy Officer for any violation of my Protected Health Information.

Patient Name	Account #
Patient Signature	Date Signed
Witness to Signature	Date Witnessed

OFFICE USE ONLY: ☐ **Verbally revoked** ☐ **Received written revocation**

☐ **Authorization revoked as of:** _____ _____

Date **Employee Initials**