Authorization for the Disclosure of Protected Health Information (Medical Records)for Treatment, Payment, or Healthcare Operations (§164.508(a)) HIPAA Privacy Rule Individual Authorization Agreement

I,________________________________, understand that as part of my health care, **Beverly Hills Fertility (BHF**) originates and maintains health records describing my health history, symptoms, examination and test results, diagnoses, treatment and any plans for future care or treatment. I understand that this information serves as:

- a basis for planning my care and treatment;
- a means of communication among the health professionals who may contribute to my health care;
- a source of information for applying my diagnosis and surgical information to my bill;
- a means by which a third-party payer can verify that services billed were actually provided;
- a tool for routine health care such as assessing quality and reviewing the competence of health care professionals

I understand that Beverly Hills Fertility's ***Notice of Privacy Practices*** provides a more complete description of the information uses and disclosures.

I understand that as part of my care and treatment it may be necessary to provide my Protected Health Information to another covered entity. I have the right to review Beverly Hills Fertility's Notice of Privacy Practices prior to signing this authorization.

PATIENT NAME: ______________________

Address: ____________________________

City/State/Zip Code:____________________

Phone#: ____________________________

Email (recommended):__________________

BEVERLY HILLS FERTILITY

AUTHORIZATION FOR RELEASE

OF

PRIVATE HEALTH INFORMATION

PHI Authorized: Medical records/information pertaining to medical history, mental or physical condition, services, rendered, or treatment, including ultrasound results, ovarian stimulation flow sheets, operative reports, laboratory studies, medical and/or billing information as indicated for medical care by BHF.

I authorize the release of my Protected Health Information (PHI):

OB Records [ ] Infertility Records [ ] Labs only [ ] All BHF Records* [ ]

***please note will not include outside physician records**

FROM: (Name & Address**)**	**TO:** (Name & Address**)**
________________________________	________________________________
________________________________	________________________________
________________________________	________________________________
________________________________	________________________________
(Fax number if applicable <5 pages)	**(Fax number if applicable <5 pages)**

I understand that:

- I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or healthcare operations by other covered entities.

  Information to be restricted________________________________

  Length of time and reason for restriction__________________________

- I may revoke this consent in writing at any time, except to the extent that Beverly Hills Fertility has already taken action in release of my PHI as indicated above.

[X] Accepted [ ] Denied

Printed Name of Patient or Legal Representative: ________________________________

Signature of Patient or Legal Representative: ________________________________

Today's Date:____________

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