OVATION FERTILITY™

THE NEXT GENERATION

## AUTHORIZATION FOR RELEASE OF CONFIDENTIAL INFORMATION (FROM OVATION FERTILITY)

Patient Name:_____ DOB_____ SSN_____
Last First MI

Partner Name:_____ DOB_____ SSN_____
Last First MI

Address:_____ City:_____ State:_____ Zip:_____

Day Phone Number: _____

I understand Ovation Fertility is authorized by me to use or disclose my Protected Health Information for a purpose other than treatment, payment, or health care operations. I have read this authorization and understand what information will be used or disclosed, who may use and disclose the information, and the recipient(s) of that information. I understand that treatment, payment, enrollment, or eligibility for benefits may not be conditioned upon me signing this authorization. I understand that when this information is used or disclosed pursuant to this authorization, it may be subject to re-disclosure by the recipient and may no longer be protected by state or federal privacy regulations. I further understand that I retain the right to revoke this authorization in writing (or orally in the case of Part 2 alcohol and drug abuse services), except to the extent, that action has been taken in reliance on this authorization. I understand that this authorization will expire 180 days after I have signed the form. I also understand that all requests will be processed within **15 business days** after receipt of a proper written request. I understand that in compliance with the Texas statute and according to rules set forth by the Texas State Board of Medical Examiners, a fee of $25.00 for the first 20 pages and $0.50 per page thereafter plus postage will be charged for records request.

❒ ***I do authorize this information to be disclosed electronically.***
❒ ***I do not authorize this information to be disclosed electronically.***

**I hereby authorize Ovation Fertility to release information from my medical record as indicated below to:**

Name of Person/Facility:_____

Address:_____ City:_____ State:_____ Zip:_____

Phone #:_____ Fax#:_____ Email:_____

Appointment Date (if applicable):_____

**Description of the information to be used or disclosed:**

For time period: From _____ To_____

- ❑ Lab reports
- ❑ Semen Analysis
- ❑ Other:_____
- ❒ Progress Notes
- ❒ Summary Sheets (IVF/FSH)

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**I specifically authorize the release of information relating to:**

- ❑ Genetic Information (including, but not limited to Genetic Test Results)
- ❑ IDS/HIV related information
- ❑ Donor egg, donor sperm, donor embryo, surrogacy, or gestational carrier

_____ _____
Signature of Patient or Legal Guardian Date

_____ _____
Signature of Partner Date

**Purpose of Disclosure:** ❑ Medical Care ❑ Insurance ❑ Other:_____

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

_____
Name of Patient or Authorized Representative

_____ _____
Signature of Partner or Date
Partner's Authorized Representative

_____
Name of Partner or Authorized Representative

_____
Description of Authorized Representative's authority to act for the patient and/or partner



6500 North Mopac Expy, Building 3, Suite 3102 • Austin, TX 78731 | Phone: 512-610-7474 | Fax: 512-610-7477 | www.OvationFertility.com