



**PATIENT AUTHORIZATION**

**CONSENT TO SHARE INFORMATION:** Infertility involves treatments with both male and female partners. **I understand and agree to allow all medical information to be shared with my spouse / partner unless I / we request otherwise.** In an effort to bring new and innovative treatments to our patients, we may participate in research studies that will help advance the field of reproductive endocrinology and infertility. Sometimes, data associated with an individual patient's treatment could be published in a medical journal or textbook. This information will always be presented anonymously and confidentially. I acknowledge that as a patient at the ReproMed Fertility Center, the **results of my treatment could be included in research publications or textbooks, but in no way will I be personally identified and this will not affect my treatment in any way.** [Patient Initial: \_\_\_\_\_ / Partner Initial: \_\_\_\_\_]

**CONTACT INFORMATION:** During the course of your treatment, we would need to contact you periodically with test results and other pertinent information. In an effort to respect your privacy, please indicate your preferences from the list below. If you have any other option, please indicate your preference below:

- |   |   |
|---|---|
| <input type="checkbox"/> Leave a message on my home phone.<br>Home phone # _____        | <input type="checkbox"/> Leave a message on my mobile phone.<br>Mobile phone# _____ |
| <input type="checkbox"/> Leave a message on my work voice mail.<br>Office phone # _____ | <input type="checkbox"/> Please do not call me at work.                             |
| <input type="checkbox"/> I will call your office for my results.                        | Other option _____  |

**MEDICAL RECORDS FEE SCHEDULE:** When I request the release of my medical records from this practice, I acknowledge the following information:

- I understand that the Texas State Board of Medical Examiners allows **2 weeks** for the processing of my records.
- Our office will copy your records **one time** (for no fee), after which we request that you be responsible for making copies from the set you have been given for any further use.
- If more than one copy of my records is requested, I understand that there is a fee which must be paid **prior** to the records being copied and mailed. According to the Texas State Board of Medical Examiners, the fee is \$25.00 for the first twenty pages and \$0.05 for each additional page plus the cost of postage.

Having read and agreeing to the above information, I hereby authorize The ReproMed Fertility Center to copy and mail my medical records as specified in the Authorization for Release of Medical records agreement. [Patient Initial: \_\_\_\_\_]

**HIPAA NOTICE OF PRIVACY PRACTICES:** I acknowledge that I have received the notice of Privacy practices for ReproMed Fertility Center.

Patient Name (print): \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Husband Name (print): \_\_\_\_\_

Husband Signature: \_\_\_\_\_ Date: \_\_\_\_\_