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Board Certified in Reproductive Endocrinology and Infertility  
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**Standard Authorization of Use and Disclosure of Protected Health Information**

**Information to Be Used or Disclosed**

The information covered by this authorization includes:

- Medical Records
- Insurance Records
- Lab Communication
- Nurse/Physician Phone calls/messages
- Pharmacy Communication
- Other Medical Provider Communications

**Purposes of Disclosure**

Information listed above will be disclosed for the following purposes:

- Communication between hospitals, doctors and other providers.
- Communication between labs, pharmacies and other medical entities.
- For Insurance billing, collections and communication with your insurance company.
- Communication with authorized Family or Other Persons

**Persons Authorized to Use or Disclose Information:**

Information Listed Above will be used or disclosed by:

A&M Endeavors, Fertility Care and/or its staff

**Persons to Whom Information May Be Disclosed**

Information described Above May be Disclosed To: (May include but not be limited to: Spouses, Family Members, Insurance Company, Other Physicians, etc.)

Name of Person/Organization	Type of Information Authorized to be Released
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**Expiration Date of Authorization**

This authorization is effective through \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ unless revoked or terminated earlier by the patient or the patient's personal representative by the appropriate form.

**Right to Terminate or Revoke Authorization**

You may revoke or terminate this authorization by submitting a written revocation to Fertility Care.

**Potential for Re-Disclosure**

Information that is disclosed under this authorization may be disclosed again by the person or organization to which it is sent. It may not be possible to ensure your right to the protection of the privacy of this information once Fertility Care discloses it to another party.

**Rights of the Individual**

- You may inspect or copy information used or disclosed under this authorization.
- You may refuse to sign this authorization.

**Effects of Refusing Authorization**

If you refuse to sign this authorization, Fertility Care will not deny you any treatment except research-related treatment or treatment that you have requested for the purpose of disclosure to others, including:

\_\_\_\_\_  
Treatment conditioned on authorization

\_\_\_\_\_  
Treatment conditioned on authorization

Signature

\_\_\_\_\_  
Name of Patient (Print or Type)

\_\_\_\_\_  
Signature of Patient

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Patient Representative  
(Required if patient is a minor or an adult who is unable to sign this form)

\_\_\_\_\_  
Relationship of Patient to Representative to Patient