Northern California Fertility Medical Center

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Phone (916) 773-2229 Fax (916) 773-8391

AUTHORIZATION FOR USE AND DISCLOSURE OF MEDICAL INFORMATION

This authorization allows the healthcare provider(s) named below to release confidential medical information and records. Note: *Information and records regarding treatment of minors, HIV or alcohol/substance abuse have special rules that require specific authorization.*

AUTHORIZATION

I hereby authorize: ____

Physician/Healthcare Facility

____

Address **City** **State** **Zip Code**

To release information regarding my medical history, illness or injury, consultation, prescriptions, treatment, diagnosis, or prognosis, including x-rays, correspondence and/or medical records by means of:

[ ]Mail [ ]Fax:________________________ [ ]Secure Email:______________________________

To: ____

Physician/Healthcare Facility

____

Address **City** **State** **Zip Code**

The medical information/records will be used for the following purpose: ___________________________

This authorization is:

- [ ] Unlimited (all records, excluding Substance Abuse, Mental Health, HIV Diagnosis/Treatment)
- [ ] Limited to the following medical information: ___________________________
- [ ] Allows NCFMC to display any pictures of your child(ren), that you send to us, in a public area.

I also consent to the specific release of the following records:

Drug/Alcohol/Substance Abuse _____ **(initial)**
Use of 3rd Party _____ **(initial)**
(donor sperm or egg, GC)

Tests for Antibodies to HIV _____ **(initial)**
HIV Diagnosis/Treatment _____ **(initial)**
Psychiatric/Mental Health _____ **(initial)**
Genetic Information _____ **(initial)**

DURATION This authorization shall be effective immediately and remain in effect for one year unless otherwise specified. ____

RESTRICTIONS Permissions for further use or disclosure of this medical information is not granted unless another authorization is obtained from me or unless such disclosure is specifically required or permitted by law. A photocopy of facsimile of this authorization shall be considered as effective and valid as the original. I have been advised of my right to receive a copy of this authorization.

______________________________ ______________________________

Signature of Patient **Patient's Date of Birth**

______________________________ ______________________________

Patient's Name (PRINT) **Date**