# Northern California Fertility Medical Center

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## 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.*

**I hereby authorize:** ______________________________________________

**Physician/Healthcare Facility**

______________________________________________ ____________________

**Address** **City** **State** **Zip Code** **Phone/Fax**

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** **Phone**

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.
- [ ] **Permits NCFMC to respond to your social media postings.**

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

| | | | |
|---|---|---|---|
| Drug/Alcohol/Substance Abuse | _______**(initial)** | Tests for Antibodies to HIV | _______**(initial)** |
| Use of 3rd Party | _______**(initial)** | HIV Diagnosis/Treatment | _______**(initial)** |
| (donor sperm or egg, GC) | | 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**