# AUTHORIZATION OF PATIENT TO DISCLOSE INFORMATION TO THIRD PARTY AND TO LEAVE MESSAGES

Reproductive Resource Center ("RRC") is committed to protecting your personal health information. However, the treatment being provided to you often necessitates sharing information with you and your spouse or another third party designated by you. We also want to make communication with you simple, convenient and effective (*i.e.*, appointments, lab results, etc.). To achieve both objectives, we are requesting you sign this Authorization and provide us the necessary information to comply with your consent.

**Refusal to sign this Authorization will not affect our treatment for you nor your eligibility for benefits of covered services in your health benefit plan.**

I, _____________________ (hereinafter also referred to as "you" or "your"), consent to and authorize the release of medical records, Protected Health Information ("PHI") (as that term is defined by the Health Insurance Portability and Accountability Act ("HIPAA")), as amended, as follows:

A. For the purposes of communicating information including PHI, RRC, through its health professional and employees, may communicate through the following media:

☐ Telephone at the following number(s): _______________ (home); _______________ (work); _______________ (cell);
May leave a message on voice mail ☐ (home); ☐ (work); ☐ (cell)
May leave a text message ☐ (home); ☐ (work); ☐ (cell
☐ Fax No. _______________;
You specifically authorize the release of the following:

| | | | |
|---|---|---|---|
| _______ | Alcohol/Drug Abuse Treatment | _______ | Mental Health |
| _______ | HIV/AIDS Status | _______ | Genetic Information |
| _______ | Third Party Reproduction | _______ | Other (Specify) |
| _______ | (donor egg, sperm donor, gestational carrier) | | |

B. You further consent and authorize RRC health professionals to communicate PHI and related information to the following third parties:

| | | |
|---|---|---|
| _____ Spouse | Name: ________________________________ | |
| _____ Family Member | Name: ________________________________ | Relation: ____________________ |
| _____ Other | Name: ________________________________ | Relation/Identify Person: _____________ |

You have been advised that this Authorization may be revoked at any time by providing RRC notice of revocation in writing. Such revocation shall not be effective for any PHI or other information included in this Authorization communicated to any permissible party identified herein prior to the effective date of the revocation.

This Authorization expires one (1) year from its effective date unless an earlier date or event occurs sooner. You have been advised and understand that any third party in receipt of PHI or other information authorized by you may redisclose such information and such information may no longer be protected by HIPAA or state law.

A facsimile copy of this Authorization shall be considered as effective and valid as the original.

| | | |
|---|---|---|
| ______________________________ | ______________________________ | ____________ |
| Patient Printed Name | Patient Signature | Date |

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