HOUSTON ASSISTED REPRODUCTIVE TECHNOLOGIES
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AUTHORIZATION FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION (PHI)

Patient Name:	DOB:
Address:	
SSN #:	Phone #:

I hereby authorize Hart Fertility Clinic to : ____ Release to / ____ Receive from

Person or Organization Phone # Fax #

Dates of Service

This information is being released for the following purpose:

____ Continued Care ____ Legal ____ Insurance ____ Disability Services ____ Other: ________________

Information to Release	
____ OB Record	____ Lab Results
____ Complete Record	____ Other: ________________________________

HIV/AIDS: I CONSENT TO THE RELEASE OF ANY POSITIVE OR NEGATIVE TEST RESULT FOR AIDS OR HIV INFECTION, ANTIBODIES TO AIDS OR INFECTION WITH ANY OTHER CAUSATIVE AGENT OF AIDS WITH THE REST OF MY MEDICAL RECORDS:
INITIAL: ____________________________ DATE______________________

I understand that the information used or disclosed may be subject to re-disclosure by the person or facility receiving it, and would then no longer be protected by Federal or Texas Privacy law.

If information is being released to me, I understand that my medical record may contain reports, test results and notes that only a physician can interpret. I understand and have been advised that I should contact my physician regarding the entries made in my medical record to prevent my misunderstanding of the information that has been written in the record. I will not hold Houston Assisted Reproductive Medicine liable for any misinterpretation of the protected health information as a result of not consulting my physician for the correct interpretation.

This authorization shall be valid for 120 days unless revoked in writing by the patient prior to expiration date.

____ ___________________
Signature of Patient or Legal Representative Date