Jerald S. Goldstein, MD | Rebecca A. Chilvers, MD | Satin S. Patel, MD

Patient's Name: ____
Address: ______________________________City: _______________
State: _______________ Zip: ______________ Phone: _______________
Date of Birth: __________________ Social Security #:___________________

Release Records From: (Please Print)
Physician/Provider: ____
Address: ______________________________City: _______________
State: _______________ Zip: ______________
Phone: ________________ Fax #:_____________________

Release Records To: (Please Print)
Physician/Provider: Fertility Specialists of Texas
Address: 5757 Warren Parkway, Suite 300 City: Frisco
State: Texas Zip: 75034
Phone: 214.618.2044 Fax #: 214.618.7838

By signing this Authorization, I authorize my Health Care Provider to disclose my protected health information.

1. **Information authorized for disclosure, if included in my records:**
   - ☐ Hormone testing results such as: E2, FSH, LH, Progesterone, AMH, Beta HCG, TSH, Prolactin
   - ☐ Progress notes regarding infertility work-up and treatment
   - ☐ Infertility treatment flowsheets and laboratory documents
   - ☐ HSG and Saline Infused Sonogram Reports
   - ☐ Operative reports with imaging for OB/GYN surgeries (D&C, Laparoscopy, Hysteroscopy, Myomectomy, etc)
   - ☐ Prenatal panel results
   - ☐ Operative/pathology report for tubal reversal (if applicable)
   - ☐ Thrombophilia testing results
   - ☐ Semen Analysis results
   - ☐ Urologists notes (if applicable)

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2. **If applicable, I also give permission** for the following "sensitive Protected Health Information" to be disclosed (please initial below):
   - ☐ Acquired Immunodeficiency Syndrome (AIDS) or Infection with Human Immunodeficiency Virus (HIV)
   - ☐ Behavioral Health Services/Psychiatric Care
   - ☐ Treatment for Alcohol and /or Drug Abuse
   - ☐ Sexually Transmitted Diseases (STD)
   - ☐ Genetic Counseling/Testing

   _______ I understand that the information disclosed pursuant to this Authorization, except
   Initial information protected by Federal and/or State regulations about confidentiality of drug or alcohol abuse records, HIV and Mental Health, may be subject to re-disclosure by the recipient and no longer protected by federal privacy regulations and other applicable state federal laws.

3. **I understand** that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the provider(s) in care. **I understand** that the revocation will not apply to my insurance company with the law provides my insurer with the right to review or contest a claim.

4. **I understand** that any disclosure of healthcare information carries with it the potential for unauthorized and future re-disclosures, as allowed by HIPPA and other federal privacy rules. If I have questions about disclosures of my health information, I can contact my provider of care.

5. This facility, its employees, officers, and physicians are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein.

Patient Signature______________________________________**Date**________________________________

____

(This Authorization must be notarized if information is being release to an attorney and or court)

State of Texas
County of _____________________________

SUBSCRIBED AND SWORN TO ME BY ____________________________________, WHO
_______________ a) is personally known to me, or
_______________ b) provided the following information to establish his/her identity:
____
on this the _____________ day of ________________________________, 2014, to certify which witness my hand and seal of office.

____ Notary Public