Fertility Specialists
OF TEXAS

fertilitytexas.com

Jerald S. Goldstein, MD
Dorette Noorhasan, MD
Rebecca A. Chilvers, MD
Satin Patel, MD

Baylor Medical Center at Frisco
5757 Warren Pkwy., Suite 300
Frisco, TX 75034
P: 214.618.2044
F: 214.618.7838

Texas Health Presbyterian Hospital Dallas
8230 Walnut Hill Lane, Suite 512
Dallas, TX 75231
P: 214.750.5500
F: 214.618.7838

Baylor Medical Center at Grapevine
1601 Lancaster Dr., Suite 160
Grapevine, TX 76051
P: 817.251.3553
F: 214.618.7838

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)

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

Fertility Specialists
OF TEXAS

fertilitytexas.com

Jerald S. Goldstein, MD
Dorette Noorhasan, MD
Rebecca A. Chilvers, MD
Satin Patel, MD

Baylor Medical Center at Frisco
5757 Warren Pkwy., Suite 300
Frisco, TX 75034
P: 214.618.2044
F: 214.618.7838

Texas Health Presbyterian Hospital Dallas
8230 Walnut Hill Lane, Suite 512
Dallas, TX 75231
P: 214.750.5500
F: 214.618.7838

Baylor Medical Center at Grapevine
1601 Lancaster Dr., Suite 160
Grapevine, TX 76051
P: 817.251.3553
F: 214.618.7838

- ☐ 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