Wayne S. Maxson, M.D.
David I. Hoffman, M.D.
Steven J. Ory, M.D.
Marcelo J. Barrionuevo, M.D.
Vanessa N. Weitzman, M.D.
Gene F. Manko, M.D.
Daniel R. Christie, M.D.
Marc R. Gualtieri, M.D.
Laurice Bou Nemer, M.D.

AUTHORIZATION FOR USE AND DISCLOSURE OF HEALTH INFORMATION DISCLOSURE OF HEALTH INFORMATION TO IVF FLORIDA

I hereby authorize the disclosure and use of my indentifiable health information as described below to IVF FLORIDA Reproductive Associates, including its staff, physicians or other authorized affiliates. I understand that if the organization authorized to receive the information is not an insurance company or healthcare provider, the released information may no longer be protected by federal privacy regulations.

Patient Name: ______________________________
First Middle/Maiden Last

Address: ______________________________
Street City State Zip

Social Security # Last 4 digits: XXX-XX-__________ Date of Birth: __________

Information to be released FROM:

Facility Name: ______________________________

Address: ______________________________

City, State
Zip Code: ______________________________

Telephone: ______________________________

Fax: ______________________________

Information to be release TO:

IVF FLORIDA Reproductive Associates
2960 North State Road 7
Suite 300

Margate, Florida 33063

Fax information to: (954) 247-6262

Check the specific information to be released: (used or disclosed)

- D Office Notes
- D Radiology Reports/Imaging x-rays
- D Laboratory/Pathology Reports
- D Pap & Breast Exam
- D Other (Specify) ______________________________

Purpose of Disclosure:

- D Medical Review
- D Legal Review
- D Insurance
- D Personal Use
- D Other: ______________________________

The named entity is authorized to (select both if applicable):

- D Use protected health information for treatment, payment and operations
- D Disclose protected health information to entity named

ATTESTATION:

I may revoke this authorization at any time by writing a letter and mailing it by certified mail, return receipt requested to the providing organization. I understand that the revocation will not apply to any information already released in reliance upon my authorization. I may not be able to revoke this authorization if its purpose was related to my insurance company.

______________________________ ______________
Signature of Patient/Legally Authorized Representative Date

______________________________ ______________
Printed Name Phone #