IVF FLORIDA
Reproductive Associates™
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# AUTHORIZATION FOR USE AND DISCLOSURE OF HEALTH INFORMATION DISCLOSURE OF HEALTH INFORMATION TO IVF FLORIDA

I hereby authorize the disclosure and use of my identifiable 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, FL 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 #