



## Contact Information

---

### Patient

First Name \*

Last Name \*

Middle Initial

Marital Status

Best Ph # To Reach You \*

OK to leave a message?

Yes

No

2nd Best Ph # To Reach You

OK to leave a message?

Yes

No

Date Of Birth \*

E-mail \*

Age \*

Address \*

City \*

State \*

Zip Code \*

DRIVER'S LIC

State

Occupation

Work Hours

Employer

City

State

Zip Code

Do You have Partner?

    

Yes      No

If yes:

**Partner**

First Name *	Last Name *	Middle Initial	Marital Status
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

Best Ph # To Reach You *	OK to leave a message?	2nd Best Ph # To Reach You	OK to leave a message?
<input type="text"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="text"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No

Date Of Birth *	E-mail *	Age *	Address *
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

City *	State *	Zip Code *	DRIVER'S LIC
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

State	Occupation	Work Hours	Employer
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

**Referral information**

---

WHOM MAY WE THANK FOR THIS REFERRAL? \*

- Physician     Friend
- Seminar     Internet
- Support Group

Name of the referrer:

# Insurance information

---

## Patient

---

PRIMARY INS

Insured's Name

Insurance ID

Type

CLAIMS ADDR

City

State

Zip Code

Phone

Do you have partner?

Yes

No

Emergency contact person (not living with you)

Relationship

Insured's Name

Insured

Do you have document to upload?

Yes

No

Patient's signature \*

Date

Partner's signature

Date



## CONTACT INFORMATION

---

### Primary Patient

Has a Uterus

Has a Penis

First Name \*

Middle Initial

Last Name \*

Age \*

Date of Birth  
(MM/DD/YY) \*

Occupation

Home Street Address \*

City \*

State \*

Zip/Postal Code \*

Country \*

E-mail \*

Reason for Visit \*

Infertility Evaluation

Sperm Insemination

Other

What are your expectations for this visit? \*

Any questions you wish to address \*

Indicate which number to call or leave messages

Phone (Home)

Phone (Work)

Do you have a spouse/partner?

Yes

No

Divorced

Other

If yes (Spouse/Partner):

First Name \*

Last Name \*

Age \*

Date of Birth  
(MM/DD/YY) \*

Occupation

Home Street Address \*

City \*

State \*

Zip/Postal Code \*

Country \*

Physician Notes (For office use only)

Who is your Ob/Gyn?

Name \*

Phone

Who is your Primary Care Physician?

Name \*

Phone



## PARTNER MEDICAL HISTORY AND INFORMATION

---

Do You have Partner? \*

Yes

No

If yes:

My Partner has a Uterus

My partner has a penis

List current medications

List any current medical problem(s)

How many caffeinated beverages (coffee, tea, soda) do you drink per day?

Do you smoke cigarettes?

Yes

No

Quit

If yes:

How many/day?

How many years ?

If quit:

When

Do you drink alcohol?

Yes

No

If yes

Beer

Wine

Liquor

Per week \*

Do you use marijuana, cocaine, or any other similar drug?

Yes

No

If yes describe:

Do you exercise?

Yes

No

If yes describe:

\* Are you aware of any radiation exposures other than X-rays?

If yes describe:

Physician Notes (for office use only)

Have you been evaluated by a urologist?

Yes  No

Have you previously conceived with another woman?

Yes  No

If yes, how many times?

Have you had a semen analysis?

Yes  No

Do you have difficulty with erections?

Yes  No

Do you have retrograde ejaculation of sperm into the bladder?

Yes  No

Have you had any of the following sexually transmitted diseases or pelvic infections?

Yes  No

If yes, check all that apply:

Chlamydia  
 Syphilis

Gonorrhea  
 HIV/AIDS

Herpes  
 Hepatitis

Genital warts/HPV  
 Other

Have you had a history of undescended testicles?

Yes  No

If yes

One side

Both

Date (mm/dd/yyyy)\*



Do you have scrotal or testicular pain?

Yes       No

If yes (Date) \*

Did you have the mumps after puberty?

Yes       No

If yes (Date) \*

Have you had prior injury to your testicles requiring hospitalization?

Yes       No

If yes (Date) \*

Have you had any fever in the last 3 months?

Yes       No

If yes (Date) \*

Have you been diagnosed with any of the following diseases?

Diabetes Mellitus       Cancer       Multiple Sclerosis       Prostatic infections       Urinary infections       High Blood Pressure

Any medications?

Have you had a vasectomy?

Yes       No

If yes (Date):

Have you had a vasectomy reversal?

Yes       No

If yes (Date):

Have you had surgery for varicocele repair?

Yes       No

If yes (Date) \*

Have you had hernia surgery?

Yes       No

If yes (Date) \*

Did you undergo any bladder or penis surgery as a child?

Yes  No

If yes (Date) \*

Are you exposed to prolonged heat in the workplace?

Yes  No

If yes (Date) \*

Are you exposed to any radiation or harmful chemicals in the workplace?

Yes  No

If yes (Date) \*

Have you had chemotherapy for cancer?

Yes  No

If yes (Date) \*

You allergic to any medications?

Yes  No

If yes (Date):

Please list and describe reactions

### Disorders in Your Family

<p>Cystic Fibrosis</p> <p><input type="checkbox"/> Yes</p> <p>If yes, please list relationship to you *</p> <input type="text"/> <p><input type="checkbox"/> No</p> <p><input type="checkbox"/> Don't know</p>	<p>Tay-Sachs disease</p> <p><input type="checkbox"/> Yes</p> <p>If yes, please list relationship to you *</p> <input type="text"/> <p><input type="checkbox"/> No</p> <p><input type="checkbox"/> Don't know</p>	<p>Canavan disease</p> <p><input type="checkbox"/> Yes</p> <p>If yes, please list relationship to you *</p> <input type="text"/> <p><input type="checkbox"/> No</p> <p><input type="checkbox"/> Don't know</p>	<p>Bloom syndrome</p> <p><input type="checkbox"/> Yes</p> <p>If yes, please list relationship to you *</p> <input type="text"/> <p><input type="checkbox"/> No</p> <p><input type="checkbox"/> Don't know</p>
<p>Gaucher disease</p> <p><input type="checkbox"/> Yes</p> <p>If yes, please list relationship to you *</p> <input type="text"/> <p><input type="checkbox"/> No</p> <p><input type="checkbox"/></p>	<p>Neimann-Pick disease</p> <p><input type="checkbox"/> Yes</p> <p>If yes, please list relationship to you *</p> <input type="text"/> <p><input type="checkbox"/> No</p> <p><input type="checkbox"/></p>	<p>Fanconi Anemia</p> <p><input type="checkbox"/> Yes</p> <p>If yes, please list relationship to you *</p> <input type="text"/> <p><input type="checkbox"/> No</p> <p><input type="checkbox"/></p>	<p>Familial Dysautonia</p> <p><input type="checkbox"/> Yes</p> <p>If yes, please list relationship to you *</p> <input type="text"/> <p><input type="checkbox"/> No</p> <p><input type="checkbox"/></p>

<p>Don't know</p> <p>Neurologic brain/spine</p> <p><input type="checkbox"/></p> <p>Yes</p> <p>If yes, please list relationship to you *</p> <p><input type="text"/></p> <p><input type="checkbox"/></p> <p>No</p> <p><input type="checkbox"/></p> <p>Don't know</p>	<p>Don't know</p> <p>Neural Tube Defects</p> <p><input type="checkbox"/></p> <p>Yes</p> <p>If yes, please list relationship to you *</p> <p><input type="text"/></p> <p><input type="checkbox"/></p> <p>No</p> <p><input type="checkbox"/></p> <p>Don't know</p>	<p>Don't know</p> <p>Bone/Skeletal Defects</p> <p><input type="checkbox"/></p> <p>Yes</p> <p>If yes, please list relationship to you *</p> <p><input type="text"/></p> <p><input type="checkbox"/></p> <p>No</p> <p><input type="checkbox"/></p> <p>Don't know</p>	<p>Don't know</p> <p>Dwarfism</p> <p><input type="checkbox"/></p> <p>Yes</p> <p>If yes, please list relationship to you *</p> <p><input type="text"/></p> <p><input type="checkbox"/></p> <p>No</p> <p><input type="checkbox"/></p> <p>Don't know</p>
<p>Developmental Delay</p> <p><input type="checkbox"/></p> <p>Yes</p> <p>If yes, please list relationship to you *</p> <p><input type="text"/></p> <p><input type="checkbox"/></p> <p>No</p> <p><input type="checkbox"/></p> <p>Don't know</p>	<p>Learning problems</p> <p><input type="checkbox"/></p> <p>Yes</p> <p>If yes, please list relationship to you *</p> <p><input type="text"/></p> <p><input type="checkbox"/></p> <p>No</p> <p><input type="checkbox"/></p> <p>Don't know</p>	<p>Polycystic kidney disease</p> <p><input type="checkbox"/></p> <p>Yes</p> <p>If yes, please list relationship to you *</p> <p><input type="text"/></p> <p><input type="checkbox"/></p> <p>No</p> <p><input type="checkbox"/></p> <p>Don't know</p>	<p>Heart defect from birth</p> <p><input type="checkbox"/></p> <p>Yes</p> <p>If yes, please list relationship to you *</p> <p><input type="text"/></p> <p><input type="checkbox"/></p> <p>No</p> <p><input type="checkbox"/></p> <p>Don't know</p>
<p>Down syndrome</p> <p><input type="checkbox"/></p> <p>Yes</p> <p>If yes, please list relationship to you *</p> <p><input type="text"/></p> <p><input type="checkbox"/></p> <p>No</p> <p><input type="checkbox"/></p> <p>Don't know</p>	<p>Other chrom. defects</p> <p><input type="checkbox"/></p> <p>Yes</p> <p>If yes, please list relationship to you *</p> <p><input type="text"/></p> <p><input type="checkbox"/></p> <p>No</p> <p><input type="checkbox"/></p> <p>Don't know</p>	<p>Marfan syndrome</p> <p><input type="checkbox"/></p> <p>Yes</p> <p>If yes, please list relationship to you *</p> <p><input type="text"/></p> <p><input type="checkbox"/></p> <p>No</p> <p><input type="checkbox"/></p> <p>Don't know</p>	<p>Hemophilia</p> <p><input type="checkbox"/></p> <p>Yes</p> <p>If yes, please list relationship to you *</p> <p><input type="text"/></p> <p><input type="checkbox"/></p> <p>No</p> <p><input type="checkbox"/></p> <p>Don't know</p>
<p>Sickle Cell Anemia</p> <p><input type="checkbox"/></p> <p>Yes</p> <p>If yes, please list relationship to you *</p> <p><input type="text"/></p> <p><input type="checkbox"/></p> <p>No</p> <p><input type="checkbox"/></p> <p>Don't know</p>	<p>Thalassemia</p> <p><input type="checkbox"/></p> <p>Yes</p> <p>If yes, please list relationship to you *</p> <p><input type="text"/></p> <p><input type="checkbox"/></p> <p>No</p> <p><input type="checkbox"/></p> <p>Don't know</p>	<p>Deafness/Blindness</p> <p><input type="checkbox"/></p> <p>Yes</p> <p>If yes, please list relationship to you *</p> <p><input type="text"/></p> <p><input type="checkbox"/></p> <p>No</p> <p><input type="checkbox"/></p> <p>Don't know</p>	<p>Hemochromatosis</p> <p><input type="checkbox"/></p> <p>Yes</p> <p>If yes, please list relationship to you *</p> <p><input type="text"/></p> <p><input type="checkbox"/></p> <p>No</p> <p><input type="checkbox"/></p> <p>Don't know</p>
<p>Thalassemia</p> <p><input type="checkbox"/></p> <p>Yes</p> <p>If yes, please list relationship to you *</p> <p><input type="text"/></p> <p><input type="checkbox"/></p> <p>No</p> <p><input type="checkbox"/></p> <p>Don't know</p>			

None of the above; Other (Please specify)

SPOUSE/MALE PARTNER'S SIGNATURE \*

Date (Male Partner) (mm/dd/yyyy) \*

Physician Notes (for office use only)

I confirm that I have reviewed the information above.



## Family History Questionnaire

---

### Genetic Family History & Pregnancy Questionnaire

Date of Appointment (mm/dd/yyyy)

### Patient Information

Patient's Name

Date Of Birth

Occupation

Address





City

State

Zip

Home Phone





Work Phone

Cell Phone

Referring Physician's  
Name

Referring Physician's  
Phone Number





### Partner Information

Partner

Yes

No

If yes (Partner):

Partner's name \*

Date of Birth  
(MM/DD/YY) \*

Occupation \*

The following questions may help your doctor or genetic counselor complete a genetic risk assessment and determine if certain genetic tests are appropriate. If you are unsure about your family history, please speak with family members.

Patient

- Chinese, Taiwanese, Asian Indian, Pakistani, Filipino or Southeast Asian
- Italian, Greek, Middle Eastern, Spanish, or Portuguese
- Jewish, French Canadian or Cajun
- African American, African descent, Black, Puerto Rican, Caribbean or Central American
- Hispanic or Mexican
- Caucasian
- Other (specify)

Specific

Partner

- Chinese, Taiwanese, Asian Indian, Pakistani, Filipino or Southeast Asian
- Italian, Greek, Middle Eastern, Spanish, or Portuguese
- Jewish, French Canadian or Cajun
- African American, African descent, Black, Puerto Rican, Caribbean or Central American
- Hispanic or Mexican
- Caucasian
- Other (specify)

Specific

Both

- Chinese, Taiwanese, Asian Indian, Pakistani, Filipino or Southeast Asian
- Italian, Greek, Middle Eastern, Spanish, or Portuguese
- Jewish, French Canadian or Cajun
- African American, African descent, Black, Puerto Rican, Caribbean or Central American
- Hispanic or Mexican
- Caucasian
- Other (specify)

Specific

# Have you, your partner or anyone in your families ever had the following conditions

Down Syndrome

Yes  No

Other Chromosome problems

Yes  No

Mental retardation, autism, or developmental delay

Yes  No

Spina bifida (open spine)

Yes  No

Anencephaly (opening in head/brain)

Yes  No

Blood disorder, such as hemophilia or sickle cell

Yes  No

Muscular dystrophy or neuromuscular disease

Yes  No

Cystic fibrosis

Yes  No

Neurofibromatosis

Yes  No

Skeletal disorder, like dwarfism

Yes  No

Polycystic kidney disease

Yes  No

Cystic fibrosis

Yes  No

Heart defect

Yes  No

Cleft lip/cleft palate

Yes  No

Blindness/deafness

Yes  No

Baby who died at birth or within first year

Yes  No

Stillborn or 2 or more pregnancy losses

Yes  No

Any birth defect not in this list

Yes  No

Any other inherited (genetic) condition

Yes  No

Any other serious medical condition or surgery

Yes  No

Are you or your partner adopted?

Yes  No

Are you and your partner related to each other (other than by marriage)?

Yes  No

Is there a history of infertility in either you and /or your partner?

Yes  No

Please specify the cause of infertility, if known

## Have you and / or your partner had:

Carrier testing for cystic fibrosis?

Yes  No

Carrier testing for any other genetic disorder?

Yes  No

Blood chromosome testing?

Yes  No

**Are you taking the following:**

Medications

Yes     No

Recreational Drugs

Yes     No

Alcoholic drinks

Yes     No

Cigarette smoking

Yes     No

If yes please list \*

Do you have diabetes, PKU (phenylketonuria) or lupus?

Yes     No

**Are you considering or have you used:**

Egg donor?

Yes     No

Donor sperm?

Yes     No

Preimplantation Genetic Diagnosis (PGD)

Yes     No

Preimplantation Genetic Screening (PGS)?

Yes     No

Intracytoplasmic sperm injection (ICSI)?

Yes     No

I have answered these questions to the best of my knowledge.

Patient Signature

Date (mm/dd/yyyy):



**Permission to Contact Insurance Carrier and Agreement of Financial  
Responsibility AUTHORIZATION FOR COASTAL FERTILITY MEDICAL  
CENTER / REPRODUCTIVE SPECIALTY LABS TO CONTACT MY  
INSURANCE CARRIER**

I authorize Coastal Fertility Medical Center/Reproductive Specialty Labs to inquire on my behalf, regarding information about my benefits and coverage. I also authorize the release of any medical or other information necessary to process my insurance claim(s)

Patient Signature \*

Date (Patient):

**AGREEMENT OF FINANCIAL RESPONSIBILITY and AUTHORIZATION  
TO BILL DESIGNATED INSURANCE CARRIER(S)**

I authorize Coastal Fertility Medical Center (CFMC) / Reproductive Specialty Labs (RSL) to bill my insurance carrier(s), and I also authorize benefits to be paid directly to CFMC and RSL. If my insurance carrier, for any reason, will not cover a particular treatment, medication, or procedure, either in full or part, I understand, and agree it is my responsibility to remit payment in full, unless prior written arrangements have been made with the CFMC/RSL billing department

Patient Signature \*

Date (Patient):

**\*\*SIGN BELOW ONLY IF YOU DO NOT WANT US TO CONTACT YOUR INSURANCE CARRIER\*\***

**DO NOT CONTACT INSURANCE CARRIER**

I wish to be a cash account. PLEASE DO NOT CONTACT MY INSURANCE CARRIER FOR ANY REASON, unless I request (in writing) for you to do so.

Patient Signature\*

Date (Patient):

Dear Patient: To assist you in understanding your infertility benefits, we ask that you call your insurance company and ask the following questions. This will give you a better understanding of how your insurance may cover your treatment at Coastal Fertility Medical Center.

## **Does my health plan participate with Lawrence Werlin, M.D. or Coastal Fertility Medical Center?**

- Does my health plan participate with Lawrence Werlin, M.D. or Coastal Fertility Medical Center?  
(TAX I.D.# 33 0870026)
- Do I have infertility benefits? If yes, then ask the following questions.
- Do I have out of network benefits?
- If you have a POS plan, ask the clerk which tier offers the best infertility coverage.
- What services are covered for infertility?
  - Consultation
  - Second Opinion?
  - Diagnostic Testing?
  - Diagnostic or Corrective Surgery?
  - Medications:
    - Oral:
    - Self Injectable:
- Treatment:
  - IUI (artificial insemination) IVF (in-vitro fertilization)
- Do I have any limits on number of attempts?
- Do I have any monetary limit?
- What is my deductible?
- Do I have an out of pocket maximum?
- Do I need pre-certification?

## Email Consent

Patient Name\*

Patient E-mail Address:\*

## RISK OF USING EMAIL

Coastal Fertility Medical Center (CFMC) offers patients the opportunity to communicate by e-mail.

Transmitting patient information by e-mail, however, has a number of risks that patients should consider before using e-mail. These include, but are not limited to, the following risks:

- E-mail can be circulated, forwarded, and stored in numerous paper and electronic files.
- E-mail can be immediately broadcast worldwide and be received by many intended and unintended recipients.
- E-mail senders can easily misaddress an email.
- Email is easier to falsify than handwritten or signed documents.
- Backup copies of e-mail may exist even after the sender or the recipient has deleted his or her copy.
- Employers and online services have a right to archive and inspect e-mails transmitted through their systems,
- E-mail can be intercepted, altered, forwarded, or used without authorization or detection.
- E-mail can be used to introduce viruses into computer systems.
- E-mail can be used as evidence in court

## CONDITION FOR THE USE OF E-MAIL

CFMC will use reasonable means to protect the security and confidentiality of e-mail information sent and received. However, because of the risks outlined above, CFMC cannot guarantee the security and confidentiality of e-mail communication and will not be liable for improper disclosure of confidential information that is not caused by Provider's intentional misconduct. Thus, patients must provide written consent, except as authorized or required by law.

Consent to the use of e-mail for patient information. Consent to the use of E-mail includes agreement with the following conditions:

- All e-mails to or from the patient concerning diagnosis or treatment will be printed out and made part of the patient's medical record. Because they are a part of the medical record, other individuals,

authorized to access the medical record, such as staff and billing personnel, will have access to those e-mails.

- Your Provider may forward e-mails internally to CFMC staff and agents as necessary for diagnosis, treatment, reimbursement, health care operations, and other handling. Your Provider will not, however forward e-mails to independent third parties without the patient's prior written Consent, except as authorized or required by law.
- Although CFMC staff will endeavor to read and respond Promptly to an e-mail from the patient, we cannot guarantee that any particular e-mail will be read and responded to within any particular period of time. Thus the patient shall not use e-mail for medical emergencies or other time-sensitive matters.
- If the patient's e-mail requires or invites a response from Provider and the patient has not received a response within a reasonable time period, it is the patient's responsibility to follow up to determine whether the intended recipient received the e-mail and when the recipient will respond.
- The patient should not use e-mail for communication regarding sensitive medical information such as information regarding sexually transmitted diseases, AIDS/HIV, mental Health, developmental disability, substance abuse.
- The patient is responsible for informing your provider of any type of information the patient does not want to be sent by e-mail, in addition to those set out in 2(e) above
- The patient is responsible for protecting his/her password or other means of access to e-mail. CFMC is not liable for breaches of confidentiality caused by the patient or any third party.
- CFMC Providers shall not engage in e-mail communication that is unlawful, such as unlawful practicing medicine across state lines.
- It is the patient's responsibility to follow up and/or schedule an appointment if warranted.

## **INSTRUCTIONS**

To communicate by e-mail, the patient shall:

- Limit or avoid use of his/her employer's computer.
- Inform CFMC of changes in his/her e-mail address.
- Put the patient's name in the body of the e-mail.
- Include the category of the communication in the e-mail's subject line, for routing purposes (e.g., billing question).
- Review the e-mail to make sure it is clear and that all relevant information is provided before sending to your Provider.
- Inform your Provider that the patient received an email from your Provider.
- Take precautions to preserve the confidentiality of e-mails, such as using screen savers and safeguarding his/her computer password.
- Withdraw consent only by e-mail or written communication to your Provider.

## **PATIENT ACKNOWLEDGMENT AND AGREEMENT**

I acknowledge that I have read and fully understand this consent form. I understand the risks associated with the communication of e-mail between CFMC staff and me, and consent to the conditions outlined herein, as well as any other instructions that Provider may impose to communicate with patients by e-mail. Any questions I may have had were answered.

Patient signature \*

Date(Patient) \*

Thank you for taking the time to make this all. When you come in for your consultation, you will meet with a financial advisor who will compare notes with your research and the verification that took place in our office. If there are any discrepancies, another call will be made by our staff to give us an accurate picture of what your insurance covers.



## ACKNOWLEDGMENT OF RECEIPT OF PRIVACY NOTICE AND ACKNOWLEDGMENT OF MEDICAL BOARD OF CALIFORNIA NOTICE TO CONSUMERS

I acknowledge that I have read the Privacy Notice

Patient or Personal Representative\*

Date\*

If Personal Representative's signature appears above, please describe Personal Representative's relationship to the patient.

Patient's signature\*

Date (Patient) \*

I HAVE READ AND AGREE TO THE FINANCIAL POLICIES ENCLOSED



**Medical Records Request Use or Disclosure Authorization**

Patient's Name (print):	Birthdate:	S.S.N:
Partner's Name (print):	Birthdate:	S.S.N:

Pursuant to the Health Insurance Portability and Accountability Act (HIPAA), I/We hereby authorize the following provider(s):

Physician's name: \_\_\_\_\_ Tel: \_\_\_\_\_ FAX: \_\_\_\_\_

Address: \_\_\_\_\_

**\*\*\* It's important that we have your doctor's fax #, please call your doctor's office for the fax #.**

To disclose the following protected health information to:

Coastal Fertility Medical Center  
15500 Sand Canyon Ave., Suite 100  
Irvine, California 92618 Tel: 949-726-0620 Fax: 949-726-0653  
Attention: Lupe Castaneda

- Medical History, including specific progress notes regarding any problems that would impact my treatments progress or outcome.
- Results of relevant diagnostic or laboratory tests.
- Other \_\_\_\_\_

This protected health information is being used by the practice for the purpose of preparation treatment at the Coastal Fertility Medical Center. This authorization shall be in force and effect until \_\_\_\_\_ (date).

I understand that, as set forth in the Practice's Privacy Notice, I have the right to revoke this authorization, in writing, at any time by sending written notification to: Coastal Fertility Medical Center, 15500 Sand Canyon, Suite 100, Irvine, California 92618, Attn: Privacy Officer

I understand that a revocation is not effective to the extent that the Practice has relied on the use or disclosure of the protected health information.

I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law.

I understand that the Practice will not condition my treatment on whether I provide authorization for the requested use or disclosure.

I understand that I have the right to:

- Inspect or copy my protected health information to be used or disclosed as permitted under federal law (or state law to the extent the state law provides greater access rights.)
- Refuse to sign this authorization.

\_\_\_\_\_  
Patient's signature Date

\_\_\_\_\_  
Partner's signature Date