Coastal Fertility Medical Center | RSMC Irvine

Release of Medical Records Use or Disclosure Authorization

Patient's Name (Print):	**Birthdate:**
Partner's Name (Print):	**Birthdate:**

Pursuant to the Health Insurance Portability and Accountability Act (HIPPA), I/We hereby authorize and request:

Coastal Fertility Medical Center
15500 Sand Canyon Ave. Suite 100
Irvine, California 92618
Telephone: (949) 726-0600 FAX: (866) 561-1388

(Specifically describe the information to be used or disclosed including meaningful descriptors such as date of service, type of service provided, level of detail to be released, origin of information, etc., or check "complete medical records"):

☐ Complete Medical Records.
☐ Psychological Evaluation Records.
☐ Other_____

This protected health information may be disclosed to:

Name: _____

Address: _____

Telephone #: _____ **FAX #:** _____

This protected health information is being used or disclosed for the following purpose:

☐ _____
☐ At my/our request(s). I/We choose not to explain the purpose of this request.

This authorization shall be in force and effect until:

☐ _____*(date).*
☐ No expiration. (Can only be used if authorization is for creation of research database or research repository)

I understand that, as set forth in the Practice's Privacy Notice, I have the right to revoke this authorization, at any given time by sending written notification to Coastal Fertility; address listed above with "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, furthermore, I understand that the information used or disclosed pursuant to this authorization may be subject to redisclosure 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:**