Coastal Fertility Medical Center | RSMC Irvine

Medical Director: Lawrence B. Werlin M.D.

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 th is 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 prov ide 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

_____