Conceptual Options
Partnering for Parenthood since 1999

Request and Authorization to Disclose Medical Records and Protected Health Information

Name of Patient: ____

Date of Birth: ________________ Social Security #: ______________________

Address: ____

Telephone: __________________ Maiden Name: ______________________

I, the undersigned patient, hereby authorize **(Name of delivering hospital and OB/GYN for all births, and IVF Clinics for previous surrogacy cycles, if applicable)**

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to use or disclose my protected health information as indicated below to:

Conceptual Options, LLC
13025 Danielson Street, Suite 200, Poway, CA 92064
Phone: (858)748-4222 Fax: (858)748-4244

Information to be released:

- ☒ History and physical exam
- ☒ Lab Reports
- ☒ Ultrasound Reports
- ☒ Consultation Report
- ☒ Medications
- ☒ Pregnancy, OB/GYN, Delivery
- ☒ PAP
- ☒ Other Pertinent Information
- ☒ HIV/AIDS-related information and testing
- ☒ Previous surrogacy cycle records

1. I understand that this authorization will expire two years from date signed. A photocopy of this form will be considered as valid as the original.
2. I understand that I may revoke this authorization at any time by notification in writing and this authorization will cease to be effective on the date notified except to the extent that action has already been taken in reliance upon it.
3. I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer be protected by Federal privacy regulations. However, other state or Federal law may prohibit the recipient from disclosing specially protected information, such as HIV/AIDS-related information and psychiatric or mental health information.
4. My health care and payment for my health care will not be affected if I do not sign this form.
5. I understand that signing this Authorization is voluntary, but is required to participate in this program.
6. I understand that I will get a copy of this form after I sign it.

Please process this request within 15 days, as provided by law.

By signing below, I acknowledge that I have read and understand this authorization.

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Patient's Signature Date