

Request and Authorization to Disclose Medical Records and Protected Health Information

Name of Patient: _____

Date of Birth: _____ Social Security #: _____

Address: _____

(Street address, including apartment or unit number – No P.O. Boxes)

(City, State and ZIP code)

Daytime Phone: _____ Evening Phone: _____

I, the undersigned patient, hereby authorize _____

(Name of current or previous physician, medical group, clinic or hospital)

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

Conceptual Options, LLC * Daisy Castro - Surrogate Intake Coordinator

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

Information to be released:

- | | |
|-----------------------------|--|
| ❖ History and physical exam | ❖ Ovum Donor Stimulation/Retrieval |
| ❖ Lab Reports | ❖ Embryo Quality Report |
| ❖ Ultrasound Reports | ❖ Other Pertinent Information |
| ❖ Consultation Report | ❖ HIV/AIDS-related information and testing |
| ❖ Medications | |

1. I understand that this authorization will expire two years from my last date of service visit. 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 of Federal law may prohibit the recipient from disclosing specially protected information, such as HIV/AIDS-related information and psychiatric/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 my refusal to sign this Authorization will not jeopardize my right to obtain present or future treatment for psychiatric disabilities except where disclosure of the information is necessary for treatment.
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.

Patient's Signature Date: _____

I, (please print) _____, hereby authorize you to release any of my medical information contained in my partner's chart, including the results of any laboratory tests for infectious disease, which may include HIV-related information, if applicable.

Partner's signature Date: _____