Chart#____________

Authorization for the Use and Disclosure of PHI

Use and Disclosure of Health Information

I, ____, hereby authorize the use or disclosure information as follows:

***All health information pertaining to insurance payment, treatment, medical history and mental or physical condition.*

Purpose of requested use or disclosure: Continuation of Treatment.

This Authorization expires one year from date of signing.

Notice of Rights:

I may refuse to sign this authorization. Understanding that doing so, NCCRM will not be able to file any claims to my insurance provider on my behalf and I will be responsible for the entire payment at the time of service. I may revoke this authorization at any time. My revocation must be in writing, signed by me or on my behalf; and delivered to the following address:

NC Center for Reproductive Medicine
400 Ashville Ave.
Suite 200
Cary, NC 27518

My revocation will be effective upon receipt. I have a right to receive a copy of this authorization. My treatment, enrollment and/or eligibility will not be conditioned on my providing or refusing to sign this authorization
Information disclosed pursuant to this authorization could be re-disclosed by the recipient and could no longer be protected by federal confidentiality law (HIPAA).
I may inspect or obtain a copy of the health information that I am being asked to use or disclose.

☐ I authorize use and disclosure of my health information.

____ ______________________
Patient Signature Date

☐ **I DO NOT** authorize use and disclosure of my health information.

____ ______________________
Patient Signature Date