Jerald S. Goldstein, MD | Rebecca A. Chilvers, MD | Satin S. Patel, MD | Daniel A. Skora, MD | Ali R. Guerami, MD

Patient's Name: ____
Address: ____City: ______________________
State: ______________________ Zip: _____________________ Phone: _______________________
Date of Birth: ___________________________ Social Security #:_____________________________

Release Records From: (Please Print)
Physician/Provider: ____
Address: ____City: ______________________
State: ______________________ Zip: _____________________
Phone: _______________________ Fax #:________________________________

Release Records To: (Please Print)
Physician/Provider: Fertility Specialists of Texas
Address: 5757 Warren Parkway, Suite 300 City: Frisco
State: Texas Zip: 75034
Phone: 214.618.2044 Fax #: 214.618.7838

By signing this Authorization, I authorize my Health Care Provider to disclose my protected health information.

1. **Information authorized for disclosure, if included in my records:**
   - ☐ Hormone testing results such as: E2, FSH, LH, Progesterone, AMH, Beta HCG, TSH, Prolactin
   - ☐ Progress notes regarding infertility work-up and treatment
   - ☐ Infertility treatment flowsheets and laboratory documents
   - ☐ HSG and Saline Infused Sonogram Reports
   - ☐ Operative reports with imaging for OB/GYN surgeries (D&C, Laparoscopy, Hysteroscopy, Myomectomy, etc)
   - ☐ Prenatal panel results
   - ☐ Operative/pathology report for tubal reversal (if applicable)
   - ☐ Thrombophilia testing results
   - ☐ Semen Analysis results
   - ☐ Urologists notes (if applicable)

2. **If applicable, I also give permission** for the following "sensitive Protected Health Information" to be disclosed (please initial below):
   - ☐ Acquired Immunodeficiency Syndrome (AIDS) or Infection with Human Immunodeficiency Virus (HIV)
   - ☐ Behavioral Health Services/Psychiatric Care
   - ☐ Treatment for Alcohol and /or Drug Abuse
   - ☐ Sexually Transmitted Diseases (STD)
   - ☐ Genetic Counseling/Testing

   ______ I understand that the information disclosed pursuant to this Authorization, except
   Initial information protected by Federal and/or State regulations about confidentiality of drug or alcohol abuse records, HIV and Mental Health, may be subject to re-disclosure by the recipient and no longer protected by federal privacy regulations and other applicable state federal laws.

3. **I understand** that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the provider(s) in care. **I understand** that the revocation will not apply to my insurance company with the law provides my insurer with the right to review or contest a claim.

4. **I understand** that any disclosure of healthcare information carries with it the potential for unauthorized and future re-disclosures, as allowed by HIPPA and other federal privacy rules. If I have questions about disclosures of my health information, I can contact my provider of care.

5. This facility, its employees, officers, and physicians are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein.

Patient Signature____________________________________**Date**_______________________________

____

(*This Authorization must be notarized if information is being release to an attorney and or court.)*

State of Texas
County of ____________________________
SUBSCRIBED AND SWORN TO ME BY ___________________________________, WHO
_______________ a) is personally known to me, or
_______________ b) provided the following information to establish his/her identity:
____
on this the _____________ day of _______________________________, 2014, to certify which witness my hand and seal of office

____Notary Public