Fertility and Surgical Associates
OF CALIFORNIA

Authorization for the Disclosure of Protected Health Information (Medical Records) for Treatment, Payment, or Healthcare Operations (§164.508(a))

HIPAA Privacy Rule Individual Authorization Agreement

I, _____ understand that as part of my health care, Fertility and Surgical Associates of California Inc., originates and maintains health records describing my health history, symptoms, examination and test results, diagnoses, treatment and any plans for future care or treatment. I understand that this information serves as:

- a basis for planning my care and treatment;
- a means of communication among the health professionals who may contribute to my health care;
- a source of information for applying my diagnosis and surgical information to my bill;
- a means by which a third-party payer can verify that services billed were actually provided;
- a tool for routine health care operations such as assessing quality and reviewing the competence of health care professionals

I have been provided with and understand that Fertility and Surgical Associates of California Inc.'s ***Notice of Privacy Practices*** provides a more complete description of the information uses and disclosures.

I understand that as part of my care and treatment it may be necessary to provide my Protected Health Information to another covered entity. I have the right to review Fertility and Surgical Associates of California Inc.'s Notice of Privacy Practices prior to signing this authorization. I authorize the disclosure of my Protected Health Information as specified below for the purposes and to the parties designated by me.

PHI Authorized: Medical records/information pertaining to medical history, mental or physical condition, services rendered, or treatment, including ultrasound results, ovarian stimulation Flowsheet, operative reports and laboratory studies.

Purpose Authorized: Medical and/or Billing information as indicated for care by FSAC.

Parties authorized to Release / Receive (circle one) my personal health information (PHI):

_____

_____

_____

I understand that:

- I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or healthcare operations by other covered entities;
- I may revoke this consent in writing at any time, except to the extent that Fertility and Surgical Associates of California Inc., has already taken action in reliance thereon.

[ ] Accepted [ ] Denied Date: …….…….

Social Security Number: ……..., Date of Birth: ……

Signature of Individual or Legal Representative Witness ……..

Printed Name of Individual or Legal Representative Witness ……