

**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 & Surgical Associates of California (FSAC)** 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 such as assessing quality and reviewing the competence of health care professionals

I understand that Fertility & Surgical Associates of California'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 & Surgical Associates of California's Notice of Privacy Practices prior to signing this authorization.

PHI Authorized: Medical records/information pertaining to medical history, mental or physical condition, services, rendered, or treatment, including ultrasound results, ovarian stimulation flow sheets, operative reports, laboratory studies, medical and/or billing information as indicated for medical care by FSAC.

I authorize the release of my Protected Health Information (PHI):

OB Records [] Infertility Records [] Labs only [] All FSAC Records* []

***please note will not include outside physician records**

FROM: (Name & Address)

TO: (Name & Address)

(Fax number if applicable <5 pages)

(Fax number if applicable <5 pages)

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;
Information to be restricted _____
Length of time and reason for restriction _____
- I may revoke this consent in writing at any time, except to the extent that Fertility & Surgical Associates of California has already taken action in release of my PHI as indicated above.

[X] Accepted [] Denied Printed Name of Patient or Legal Representative: _____

Signature of Patient or Legal Representative: _____

Last 4 Digits of Social Security Number: _____ Date of Birth: _____

Today's Date: _____ Patient's Current Contact Phone Number: _____

FSAC Tel (805) 778-1122 / FAX: 805-778-0610 (Medical Records Dept.)

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