KENTUCKY FERTILITY INSTITUTE

4612 Chamberlain Lane #200
Louisville, KY 40241
Tel: (502) 996-4480
Fax: (502) 996-4481

AUTHORIZATION FOR THE RELEASE OF INFORMATION

Authorization for Use and Disclosure of Protected Health Information (PHI)
This authorization is in accordance with Federal Privacy Laws

Patient information:

Last name_____First_____Middle_____
Maiden name_____Address_____
City_____State_____Zip_____
SSN_____-_____-_____Date of Birth_____/_____/_____ Phone(_____)_____-_____

I, the above identified person, do hereby authorize the release of my PHI as indicated (identify name/group/entity).

FROM: _____
_____
_____
_____
Phone(_____)_____-_____
Fax(_____)_____-_____

TO: **Kentucky Fertility Institute, LLC**
4612 Chamberlain Lane, Suite 200
Louisville, KY 40241
Tel: (502) 996-4481
Fax: (502) 996-4481

This authorization covers the following periods of healthcare (check one):

- ☐ All Periods of Healthcare
- ☐ From _____/_____/_____ To _____/_____/_____

Protected Health Information (PHI) to be used or disclosed (check box or boxes):

- ☐ Entire Healthcare record
- ☐ Obstetrical Records
- ☐ History/Physical Notes
- ☐ Office Notes/Dictations
- ☐ Surgery Procedure and Pathology Reports
- ☐ Radiology Reports and Images
- ☐ Previous fertility treatment records
- ☐ Lab Results (including HIV and STI testing)
- ☐ Consultation Reports
- ☐ Psychotherapy Notes
- ☐ Other:_____

This information is being disclosed for the following reasons (check box or boxes):

- ☐ Continued Care/Treatment
- ☐ Patient Request
- ☐ Obstetrical Care
- ☐ Legal Reasons
- ☐ Insurance
- ☐ Workman's Compensation
- ☐ Personal Use
- ☐ Disability
- ☐ Other:_____

This Authorization will expire in one year unless otherwise specified:

I understand that I/my legal representative may revoke this authorization in writing at any time, except to the extent that action has already been taken in reliance on this authorization or according to law. Written revocation must be sent to the person that I authorized to release my information.

I hereby certify that I have read the provisions set forth in this authorization. I understand and agree to its terms.

Patient Signature_____ **Date** _____/_____/_____