

NEVADA CENTER FOR REPRODUCTIVE MEDICINE

HIPAA PRIVACY RULE AUTHORIZATION  
FOR RELEASE OF HEALTH INFORMATION

I, \_\_\_\_\_ authorize the specified person(s) or company to disclose protected health information as follows:

1. Company authorized to make disclosure: NCRM
2. Person authorized to receive the disclosed information:  
Partner \_\_\_\_\_ Other \_\_\_\_\_
3. Specific description of the protected health information that may be used or disclosed: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
4. I understand that the information received pursuant to this authorization may be disclosed by the recipient and might lose its protected status.
5. I understand that I may revoke this authorization by giving written notice to a representative of The Nevada Center For Reproductive Medicine.
6. I understand that I am entitled to receive a copy of this authorization.
7. I understand that after this information is disclosed, federal law might not protect it, and the recipient might re-disclose it.
8. I give authorization to the representative of NCRM to leave protected information on my home answering machine, or my cell voice mail.  
(Initial here)

SIGNATURE OF PATIENT \_\_\_\_\_ DATE: \_\_\_\_\_

NAME: \_\_\_\_\_

WITNESS: \_\_\_\_\_ DATE: \_\_\_\_\_