

NEVADA CENTER FOR REPRODUCTIVE MEDICINE

HIPAA PRIVACY RULE AUTHORIZATION
FOR RELEASE OF HEALTH INFORMATION

I, _____ authorize the specified person(s) or
(Female Patient)
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 representatives of NCRM to leave protected health, information on the following:

Circle one Initial here

- | | | | |
|---------------------------|-----|----|-------|
| 1. Home answering machine | yes | no | _____ |
| 2. Cell phone voice mail | yes | no | _____ |
| 3. Work voice mail | yes | no | _____ |

NAME: _____ DATE: _____

SIGNATURE OF PATIENT : _____

WITNESS: _____

NEVADA CENTER FOR REPRODUCTIVE MEDICINE

HIPAA PRIVACY RULE AUTHORIZATION
FOR RELEASE OF HEALTH INFORMATION

I, _____ authorize the specified person(s) or
(Male Patient)
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 representatives of NCRM to leave protected health, information on the following:

Circle one Initial here

- | | | | |
|---------------------------|-----|----|-------|
| 1. Home answering machine | yes | no | _____ |
| 2. Cell phone voice mail | yes | no | _____ |
| 3. Work voice mail | yes | no | _____ |

NAME: _____ DATE: _____

SIGNATURE OF PATIENT : _____

WITNESS: _____