West Virginia Fertility Institute Inc.

Authorization to Release Health Information

Patient Information:

Name of Patient _____ Date of Birth _____ Address _____

City, State, Zip _____ Phone _____

_____ **may release the following information:**
(Name of the entity)

___ Entire record ___ Financial records ___ Office visit notes
___ Marketing
___ Psychotherapy notes -if this box is checked only psychotherapy notes may be released.
___ Diagnostic studies (list):

___ Other as listed

Entity or person who will receive the information:

Name _____

Address _____

City, State, Zip _____ Phone _____

___ Send the information via FAX to # _____

This authorization shall be in effect until the information has been forwarded as requested or until the course of treatment is complete.

Patient Rights:

- I have the right to revoke this authorization at any time.
- I may inspect or copy the protected health information to be disclosed as described in this document.
- Revocation is not effective in cases where the information has already been disclosed but will be effective going forward.
- Information used or disclosed as a result of this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law.
- I may refuse to sign this authorization and that my treatment will not be conditioned on signing.
- I understand released information may include a communicable disease diagnosis such as HIV.

_____ Date _____
Signature of Patient or Personal Representative

_____
Description of Personal Representative's Authority (attach necessary documentation)

Revised May 2020