CARE SURROGACY

Authorization To Disclose Personal Health Information

This form is used to advise CARE Surrogacy of the person or persons you have chosen to have access to your personal health information. 'Personal health information,' means individually identifiable health information. It is information about you, including your name, address and medical information and may relate to your past, present or future physical/mental health or conditions.

1. I* authorize _____ to disclose my protected health information and/or records as described below.
2. I authorize the above person or organization to release any and all health information in their possession unless otherwise indicated below. Information to be released may include (but not limited to):

__Medication Records	__List of Allergies
__Physical Exams	__Invoices
__Laboratory Results	__Insurance Claims Forms
__Hormonal Profile	__Entire Record from (date)_____ to (date)_____
__Estradiol	__Stimulation Sheet
__Radiology Images	__Post Donor Report
__Ultrasounds	__Abstract
__Consultation Reports	__Other_____
__Do Not Release _____	

3. I understand that the information in my health records may include information relating to Sexually Transmitted Diseases (STD), Acquired Immunodeficiency Syndrome (AIDS), or Human Immunodeficiency Virus (HIV), Mental/Behavioral Health, and Substance/Alcohol Abuse.
4. This information may be disclosed to the following person(s) or organization(s): _____.
5. I understand I have the right to revoke this authorization at any time by submitting a request in writing to CARE Surrogacy. I understand the revocation will not apply to information that has already been released in response to this authorization. Unless otherwise revoked, this authorization will expire on the following date, event or condition: _____. If I fail to specify an expiration date, event or condition, this authorization will expire in 6 months from the date below.
6. I understand that authorizing the disclosure of this health information is voluntary. Authorization or refusal to authorize disclosure of my personal health information will have no effect on my treatment. I understand that my personal health information may be re-disclosed by the person(s) or organization(s) and may no longer be protected by law. If I have questions about disclosure of my health information, I can contact my attorney.

Print Name _____ **Patient Signature**_____
Date: _____

***Identifying Information: Patient must provide copy of identification (acceptable identification includes driver's license, identification card, passport, birth certificate, benefits identification card, state or federal employee id card)**