Seattle Reproductive Medicine®
AN INTEGRAMED® AFFILIATE

Authorization Form to Release Protected Health Information (PHI) To Spouse / Significant Other

This Authorization grants permission to my Spouse / Significant Other / Party Named Below to: make or confirm appointments; have access to radiology, laboratory, or test findings; have access to telephone communication and answering machine messages as well as other common means of communication; pick up medications; be made aware of my diagnosis, prognosis, and fertility treatment plans; and have access to my financial health information.

I hereby authorize Seattle Reproductive Medicine to use and disclose my individually identifiable health information as described above. I understand that this authorization is voluntary. I understand that once this information is disclosed to my spouse / significant other, or the party named below, the released information may no longer be protected by federal privacy regulations.

PATIENT NAME: ____

Date of Birth: __________________ **MR#:** ____________________

Spouse / Significant Other / Other:____________________________________

Relationship to Patient: ____

Address: ____

Phone: ____

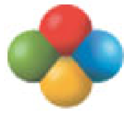
If address or phone number is different from Patient's, please provide information:

____

The patient must read and initial the following statements:

1. I understand that this authorization will (Please check one)
    - o Expire 1 year from the date signed by the patient
    - o Be effective for the lifetime of the patient unless revoked (see # 2 below)

    Patient's Initials: _____________



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2. I understand that I may revoke this authorization at any time by notifying Seattle Reproductive Medicine in writing; however, if I do revoke the authorization, it will not have any effect on any actions taken by Seattle Reproductive Medicine prior to their receipt of the revocation.

   Patient's Initials: ________________

3. I understand that my treatment cannot be conditioned on whether I sign this authorization.

   Patient's Initials: ________________

(Form must be completed before signing or will not be valid)

Patient's Signature: ____

Date: ____

* * YOU MAY REFUSE TO SIGN THIS AUTHORIZATION * *

ACKNOWLEDGEMENT FORM
JOINT NOTICE OF PRIVACY PRACTICES

This is to acknowledge that I have received a copy Seattle Reproductive Medicine's *Joint Notice of Privacy Practices*

Name: ____

Patient ID Number: ____

Signature: ________________________________ **Date:** _____________________

Disposition: File this Acknowledgement Form in the patient's medical record.

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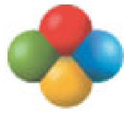

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