CONSENT FOR THIRD PARTY DISCLOSURE OF MEDICAL INFORMATION AND/OR USE OF LANGUAGE INTERPRETERS

I/We

Patient Name _____ Partner Name _____

Address: _____

Chart Number: _____

authorize the Regional Fertility Program to disclose and release my health information described below to:

Name _____ Relationship _____

Address _____

Telephone number _____ e-mail _____

For the purpose of _____

Health Information to be disclosed:
□ **Disclose** my complete health record (including but not limited to diagnoses, lab tests, prognosis, treatment, and billing, for all conditions) **OR**
□ **Disclose** my health record, as above, **BUT do not disclose** the following (check as appropriate):
- □ Mental health records
- □ Communicable diseases (including HIV and AIDS)
- □ Alcohol/drug abuse treatment
- □ Other (please specify): _____

I understand why I have been asked to disclose my health information and I am aware of the risks and benefits of consenting or refusing to consent. Information that is disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer be protected by the *Health Information Act*. I understand that this consent is effective immediately on the date that this consent is signed and valid for an indefinite period unless I inform the Regional Fertility Program in writing. I am aware that I may revoke this consent in writing at any time.

Patient Name (Print) _____ Signature _____

Partner Name (Print) _____ Signature _____

Witness Name (Print) _____ Signature _____

Date (YYYY-MM-DD): _____

Initials: Patient _____ Partner _____