Authorization for the Disclosure of Protected Health Information (Medical Records)
for Treatment, Payment, or Healthcare Operations (§164.508(a))
HIPAA Privacy Rule Individual Authorization Agreement

I, _____, understand that as part of my health care, **Fertility & Surgical Associates of California (FSAC**) originates and maintains health records describing my health history, symptoms, examination and test results, diagnoses, treatment and any plans for future care or treatment. I understand that this information serves as:

- a basis for planning my care and treatment;
- a means of communication among the health professionals who may contribute to my health care;
- a source of information for applying my diagnosis and surgical information to my bill;
- a means by which a third-party payer can verify that services billed were actually provided;
- a tool for routine health care such as assessing quality and reviewing the competence of health care professionals

I understand that Fertility & Surgical Associates of California's ***Notice of Privacy Practices*** provides a more complete description of the information uses and disclosures.

I understand that as part of my care and treatment it may be necessary to provide my Protected Health Information to another covered entity. I have the right to review Fertility & Surgical Associates of California's Notice of Privacy Practices prior to signing this authorization.

PHI Authorized: Medical records/information pertaining to medical history, mental or physical condition, services, rendered, or treatment, including ultrasound results, ovarian stimulation flow sheets, operative reports, laboratory studies, medical and/or billing information as indicated for medical care by FSAC.

I authorize the release of my Protected Health Information (PHI):
OB Records [ ] Infertility Records [ ] Labs only [ ] All FSAC Records* [ ]
***please note will not include outside physician records**

FROM: (Name & Address**)**	**TO:** (Name & Address**)**
_____	_____
_____	_____
_____	_____
_____	_____
(Fax number if applicable <5 pages)	**(Fax number if applicable <5 pages)**

I understand that:

- I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or healthcare operations by other covered entities;
  Information to be restricted_____
  Length of time and reason for restriction_____
- I may revoke this consent in writing at any time, except to the extent that Fertility & Surgical Associates of California has already taken action in release of my PHI as indicated above.

[X] Accepted [ ] Denied Printed Name of Patient or Legal Representative: _____

Signature of Patient or Legal Representative: _____

Last 4 Digits of Social Security Number: _____ Date of Birth: _____

Today's Date: _____ Patient's Current Contact Phone Number: _____

FSAC Tel (805) 778-1122 / FAX: 805-778-0610 (Medical Records Dept.)
325 Rolling Oaks Drive, Suite 110, Thousand Oaks, CA 91361
2428 Santa Monica Blvd Suite 301, Santa Monica, Ca 90404
5400 Balboa Boulevard, Suite 312, Encino, CA 91316