MID-IOWA FERTILITY
Extraordinary care. Extraordinary results.

HIPAA – Authorization to Release
Protected Health Information (PHI)
Please complete form in dark blue or black ink only

Patient Name: _____Date of Birth: _____

Please list in order of preference the number(s) where you wish to phoned, or where we may leave a message. ***We will only use this/these numbers.***

#1: (_____)_____-_____ this is _____: home / work / cell number.
My/Spouse's/Parent's *Circle One*

#2: (_____)_____-_____ this is _____: home / work / cell number.
My/Spouse's/Parent's *Circle One*

#3: (_____)_____-_____ this is _____: home / work / cell number.
My/Spouse's/Parent's *Circle One*

By signing below, I hereby authorize Mid-Iowa Fertility, P.C. to release my PHI to the following individual(s):

Name_____Relationship_____

Name_____Relationship_____

PHI will only be available to the individuals listed for 1 year from date form is signed.

Our Administrative Staff, including the Financial Specialist, often uses email to correspond for insurance and billing questions. *I understand by providing my e-mail address here, I authorize Mid-Iowa Fertility, P.C. and its staff to communicate electronically with me.*

_____@_____.com

By signing below, I acknowledge that it is my responsibility to notify Mid Iowa Fertility of any changes to the above information

_____
Patient Signature (or Legal Guardian) Date