THE MIDWEST CENTER FOR REPRODUCTIVE HEALTH, P.A.

MCRH Alpha Medical, P.A.

Great Planes Reproductive Center, P.A.

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Patient Authorization for Disclosure of Protected Health Information (PHI)

The Patient Authorization for Disclosure of Protected Health Information (PHI) Form will give our office the authority to provide the person or entity you and your spouse/partner (if applicable) designate on the form with access to your protected health information (PHI). The Patient Authorization is limited to accessing only the information that you and your spouse/partner (if applicable) designate and does not give any other rights to the person you have named on the form. Use of this form will enable us to provide your joint health information to a person or entity that may be involved in your healthcare. Due to the nature of treatment received at MCRH and its subsidiaries, records for patient and spouse/partner will be maintained jointly and this Authorization pertains to all medical records regarding patient and spouse/partner (if applicable).
The following outline will describe the information we will need on the form and its purpose. Please address any questions you have with our staff.

Directions for Completion of: Patient Authorization for Disclosure of Protected Health Information (PHI) Form

Patient Information: Please complete the entire section with patient demographic information.

Clinic/Health Provider: This identifies who is to provide the release of your Protected Health Information.

Receiving Party: This information identifies a person or entity you and your spouse/partner (if applicable) have authorized the Provider to release your PHI.

Description of Information to be Disclosed: The type and amount of health information that we disclose is determined by you and your spouse/partner (if applicable). MCRH can disclose or provide access to all of your health information or it can be limited to a specific item.

Release Type: This information tells us how you would like your PHI transmitted to a person or entity. Please see our Authorization for Release of Protected Health Information (PHI) Form for more information. If you wish to view your records, please contact MCRH at 800-508-9763 to schedule a medical record review appointment.

Release Purpose: The purpose of the release of PHI is required to be documented by MCRH.

Termination or Expiration: The Authorization will expire 12 months from your dated signature below, unless you specify an earlier termination. You must renew or submit a new Authorization after the expiration date to continue the Authorization. Please list the date of expiration if earlier than that date. You have the right to terminate the Authorization at any time by submitting a written request to our Privacy Manager. Termination of this Authorization will be effective upon written notice, except where a disclosure has already been made based on prior authorization. MCRH may require a signed Authorization on disclosures.

Redisclosure Statement: The practice places no condition to sign the Authorization on the delivery of healthcare or treatment. MCRH has no control over the entity/person(s) you have listed to receive your PHI. Therefore, your PHI disclosure under this authorization may no longer be protected by the requirements of the Privacy Rule and will no longer be the responsibility of the practice.

Secure Communication: By selecting the method(s) of delivery of your PHI, (mail, e-mail or fax) you understand and accept that information may be compromised during transmission to, or from MCRH.

Signature and Date: Because your medical records are kept jointly at MCRH, both patient and spouse/partner (if applicable) will need to sign and date the Authorization. PHI on both parties will be released unless indicated under Information to be released.

Copies: We will provide you with a copy of this signed authorization upon request.

The Midwest Center for Reproductive Health, P.A. and its subsidiaries MCRH Alpha, P.A, and Great Planes Reproductive Centers, P.A.

PATIENT AUTHORIZATION FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION (PHI)

PATIENT INFORMATION	**Name:**____________________ **Date of Birth:**__________ **Address:**____________________ **Day Phone:** __________ **City:**____________ **State:**__________ **Zip:** ________
CLINIC/HOSPITAL/ HEALTH CARE PROVIDER *(**Who** has the information you want released?)*	☐ Midwest Center for Reproductive Health, P.A. and its subsidiaries **Name:**______________________________ **Address:**____________________ **Day Phone:** __________ **City:**____________ **State:**__________ **Zip:** ________
RECEIVING PARTY *(**Where** do you want to information sent or who may have a copy of your PHI per your request?)*	☐ Midwest Center for Reproductive Health, P.A. *OR* ☐ SELF 12000 Elm Creek Blvd N, Suite 350, Maple Grove, MN 55369 Ph.: 800-508-9763 Fax: 763-494-7766 *OR* **Name:**______________________________ **Address:**____________________ **Day Phone:** _ **City:**____________ **State:**__________ **Zip:** ________
INFORMATION TO BE RELEASED (***What** do you want sent or released? Check the applicable box)*	___Records checked below ____ Billing information **FEMALE:** ☐ Operative report(s)/Biopsy reports ☐ Current pap ☐Flow sheet from ovulation cycles ☐ HSG/Sono reports and films ☐ Post coital results ☐ Info from IVF cycles clinical / lab ☐Blood tests including infectious disease ☐Rubella Other__________ **MALE:** ☐ Semen analysis results ☐ Urology-Operative reports Other __________
RELEASE INSTRUCTIONS (**How** and **when** do you want the information?)	Date Information is Needed:__________ ***please allow 7-10 business days for processing* ***please review policy for details* Release Method/Format Request: (Check **ONE**) ☐ Paper ☐ E-mail (encrypted) ☐ Fax ☐ View my records
PURPOSE OF RELEASE *(**Why** this is needed?)*	☐ Continuing care ☐ Transfer of care ☐ Insurance application ☐ Personal use or review ☐ Insurance payment/claim ☐ Litigation/Legal ☐ Other:________________

- This Authorization will expire 12 months from your dated signature below, unless you specify an earlier termination. You must renew or submit a new Authorization after the expiration date to continue the Authorization. Please list the date of expiration if earlier than 12 months from the dated signature below. _______
- You have the right to terminate this Authorization at any time by submitting a written request to our Privacy Manager. Termination of this Authorization will be effective upon written notice, except where a disclosure has already been made based on prior authorization.
- The practice places no condition to sign this Authorization on the delivery of healthcare or treatment. MCRH has no control over the entity/person(s) you have listed to receive your protected health information or the potential of compromised transmission of information. Therefore, your PHI disclosure under this Authorization may no longer be protected by the requirements of the Privacy Rule and will no longer be the responsibility of the practice.
- Your signature indicates your authorization to disclose your PHI as described above.

BOTH SIGNATURES ARE REQUIRED

PATIENT NAME ____________________ **(Printed)** **PATIENT SIGNATURE** ____________________ **Date**__________

SPOUSE/ PARTNER NAME ____________________ **(Printed)** **SPOUSE/ PARTNER SIGNATURE** ____________________ **Date**__________