



## 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)
  - Expire 1 year from the date signed by the patient
  - Be effective for the lifetime of the patient unless revoked (see # 2 below)

**Patient's Initials:** \_\_\_\_\_

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 \* \*

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***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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**PATIENT NAME:** \_\_\_\_\_

**Date of Birth:** \_\_\_\_\_ **MR#:** \_\_\_\_\_

**Spouse / Significant Other / Other:** \_\_\_\_\_

**Relationship to Patient:** \_\_\_\_\_

**Address:** \_\_\_\_\_

**Phone:** \_\_\_\_\_

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**Patient's Signature:** \_\_\_\_\_

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**Name:** \_\_\_\_\_

**Patient ID Number:** \_\_\_\_\_

**Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

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