

Mid-Iowa Fertility, P.C.

HIPAA – Authorization to Release Protected Health Information (PHI)

Patient Name _____ Date of Birth _____

Please list in order of preference the number(s) where you wish to be phoned, or 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 _____

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

I further authorize Mid-Iowa Fertility, P.C. to release my PHI to the insurance carrier(s) I have provided in order to facilitate claim payment. I permit a copy of this authorization with my signature to be used in place of the original and request payment for claims be paid directly to Mid-Iowa Fertility, P.C. I understand I am responsible for all services received regardless of insurance payment or denial.

Patient Signature (or Legal Guardian)

Date

*****Please complete form using blue or black ink only.***