Atlantic Reproductive Medicine Specialists

AUTHORIZATION FOR RELEASE OF INFORMATION

I, _____ hereby authorize Atlantic Reproductive Medicine Specialists to
Full Legal Name
release my protected health information in the following manner and to the identified persons:

☒ All health information pertaining to insurance payment, any information concerning healthcare, advice, treatment or supplies provided to me by Atlantic Reproductive Medicine Specialists.

Patient Rights

- I have the right to refuse to sign this Authorization and my treatment will not be conditioned on signing. Understanding that by doing so, Atlantic Reproductive Medicine Specialists will not be responsible for filing any claims to my insurance carrier on my behalf.
- I have the right to revoke this authorization at any time. My revocation must be in writing, signed by me, and delivered to the following address: 10208 Cerny Street, Suite 306, Raleigh, NC 27617. My revocation will be effective upon receipt.
- I may inspect or obtain a copy of the health information that I am being asked to use or disclose.
- Information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal confidentiality law (HIPAA).

I will allow release of PHI and/or financial information to the person(s) listed below:

Name: _____ DOB: _____ Relationship to patient: _____

Name: _____ DOB: _____ Relationship to patient: _____

Referring MD: _____ Primary Care Provider: _____

OB/GYN: _____ Other Medical Provider: _____

In addition, I request that you restrict my information in the following way: _____

_____

I understand this authorization will remain in effect until revoked by the patient.

PATIENT SIGNATURE: _____ **DATE:** _____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I have been provided access to the Atlantic Reproductive Medicine Specialists Notice of Privacy Practices:

- It informs me how Atlantic Reproductive Medicine Specialists will use my health information during my treatment, payment for my treatment, and Atlantic Reproductive Medicine Specialists health care operation.
- The Notice explains in more detail how Atlantic Reproductive Medicine Specialists may use and share my health information for other treatment, payment, and health care operations.
- Atlantic Reproductive Medicine Specialists will also use and share my health information as required/permitted by law.

I hereby acknowledge that I have been given an opportunity to read a copy of Atlantic Reproductive Medicine Specialists Notice of Privacy Practices. I understand that if I have any questions regarding the Notice or my privacy rights, I can contact the Privacy Officer at 919-248-8777.

(check one) ☐ **I accept receipt of Notice of Privacy Practices** ☐ **I DO NOT accept receipt of Notice of Privacy Practices**

PATIENT SIGNATURE: _____ **DATE:** _____

ACKNOWLEDGEMENT OF RECEIPT OF ARMS FINANCIAL POLICY

I hereby acknowledge I have read and have been given the opportunity to request clarification of any policy not fully understood. By signing below, I fully understand the financial policy and accept responsibility for any payment that becomes due as outlined.

PATIENT SIGNATURE: _____ **DATE:** _____