CRM

CENTER FOR REPRODUCTIVE MEDICINE

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Board Certified
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Chief Embryologist

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Embryologist

AUTHORIZATION FOR USE AND/OR RELEASE OF INFORMATION

Patient Name: _____
First Middle/Maiden Last

Address: _____
Street City State Zip

Social Security #: _____ Date of Birth: _____

Name and Address of covered entity authorized to use and/or release information:

Center for Reproductive Medicine
3435 Pinehurst Avenue, Orlando, FL 32804
410 Celebration Place; Suite 205, Celebration, FL 34747
795 Primera Boulevard; Suite 1001, Lake Mary, FL 32746

The above named entity is authorized to disclose protected health information to the entity or individuals named below:

Name of entity or individual to receive information (if applicable):

NAME: _____RELATIONSHIP TO PATIENT: _____

NAME: _____RELATIONSHIP TO PATIENT: _____

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It is frequently necessary for personnel at CRM to communicate lab results, instructions, information about treatment, and other protected health information with our patients. In the event that our personnel are not able to speak with you directly, what are the ways we can communicate it to you (check all that apply):

☐ Leave Voice Mail for me at phone number: _____

☐ Leave Message With: _____ at phone number: _____

☐ Leave Message With: _____ at phone number: _____

☐ Other: _____

The above named entity is authorized to leave voice messages regarding my treatment at the numbers listed above: _____ YES **_____** NO

This authorization shall be in force and full effect until: Date of expiration _____ (or) the conclusion of my treatment at the Center for Reproductive Medicine.

Printed Name: _____

Signature: _____ **Date**: _____