



MARGATE OFFICE
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Authorization for Use and Disclosure of Health Information
Disclosure of Health Information to IVF FLORIDA

I hereby authorize the disclosure and use of my identifiable health information as described below to IVF FLORIDA Reproductive Associates, including its staff, physicians or other authorized affiliates. I understand that if the organization authorized to receive the information is not an insurance company or healthcare provider; the release information may no longer be protected by federal privacy regulations.

Patient Name: First Middle/Maiden Last

Address: Street City State Zip

Social Security # Last 4 digits: XXX-XX- Date of Birth:

Information to be released FROM:

Information to be released TO:

Facility Name:
Address:
City, State, Zip Code:
Telephone:
Fax:

IVF FLORIDA Reproductive Associates
2960 North State Road 7
Suite 300
Margate Florida 33065

Fax information to: (954) 247-6262

Check the specific information to be released: (used or disclosed)

- Office Notes
Radiology Reports/Imaging x-rays
Laboratory/Pathology Reports
Pap & Breast Exam
Other (Specify)

Purpose of Disclosure:

- Medical Review
Legal Review
Insurance
Personal Use
Other:

The named entity is authorized to (select both if applicable):

- Use protected health information for treatment, payment and operations
Disclose protected health information to entity named

ATTESTATION:

I may revoke this authorization at any time by writing a letter and mailing it by certified mail, return receipt requested to the providing organization. I understand that the revocation will not apply to any information already released in reliance upon my authorization. I may not be able to revoke this authorization if its purpose was related to my insurance company.

Signature of Patient/Legally Authorized Representative

Date

Printed Name

Phone #