FOR SENSITIVE DIAGNOSIS ONLY

AUTHORIZATION FOR RELEASE OF INFORMATION

ANY USE AS AN AUTHORIZATION TO USE OR DISCLOSE PSYCHOTHERAPY NOTES MAY NOT BE COMBINED WITH ANOTHER AUTHORIZATION EXCEPT ONE TO USE OR DISCLOSE PSYCHOTHERAPY NOTES.

Beneficiary name _____ Sponsor ID Number _____

Beneficiary Street, city, state, zip: _____ Beneficiary S.S. number _____

I authorize the use or disclosure of the above-name beneficiary personal health information by Audubon Fertility and Reproductive Medicine as describe below: **(ONLY ONE CHECK BOX BELOW IS ALLOWABLE, PER FORM)**

- ☐ Pregnancy & Birth Control Records
- ☐ Genetic Screening Lab Results
- ☐ AIDS & STDS Records
- ☐ Mental Health Records

(Nature of Information, as limited as possible: _____)

This information may be disclosed to, and used by, the following individual or organization:

Name: _____

Address: _____

This information is being disclosed for the following purpose(s):

☐ Personal Use ☐ Continued Medical Care ☐ School ☐ Other_____

☐ Insurance Claims ☐ Retirement/Separation ☐ Legal (Purpose of disclosure, as specific as possible)

By signing below, the beneficiary or the beneficiary's representative agrees to the following statements:

1. I understand that my health care and the payment for my health care will not be affected if I do not sign this form.
2. I understand that I may see and copy the information described on this form if I ask for it, and that I get a copy of this form after I sign it.
3. I understand that I may revoke this authorization at any time. I understand that in order to revoke this authorization, I must do so in writing and send my written revocation to AFRM's Privacy Office to the address below. I understand that the revocation will not apply to information that has already been released in response to the authorization.
4. I understand that once the information is disclosed pursuant to this authorization, it may be re-disclosed by the recipient and the information may not be protected by federal privacy regulations
5. I understand that my records are protected under the federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42 CFR Part 2, and cannot be disclosed without my written consent unless otherwise provided for in the Regulations.

Must be completed for all authorizations

I understand that I may refuse to sign this authorization and that AFRM may not condition treatment or payment on whether I sign this authorization. If no expiration date is specified then this authorization will expire one year from the date of signature.

Expiration Date
_____/_____/_____
(MM) (DD) (YR)

Signature of beneficiary or beneficiary's representative _____ Representative relation to beneficiary _____

Signature of parent, guardian or authorized representative, when required _____ Date (MM/DD/YR) _____

(State/federal law commonly state that information related to alcohol/drug treatment, genetic screening, abortion, venereal disease, and/or AIDS cannot be disclosed without written consent of the patient/beneficiary. In some instances, information related to mental health and pregnancy/birth control may also require written consent of the patient/beneficiary.) AFRM will follow all Federal and state laws and regulations that are more stringent.

Return completed form to:
Audubon Fertility & Reproductive Medicine
Attn: Medical Records
4321 Magnolia Street
New Orleans, LA 70115

If signed by legal representative, please provide representative documentation as required by state law, i.e. Power of Attorney, Health Care Surrogate, Living Will or Guardianship papers. AFRM WILL NOT PROCESS INVALID FORMS.

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INSTRUCTIONS FOR COMPLETING AUTHORIZATION FOR RELEASE OF INFORMATION SENSITIVE DIAGNOSIS FORM

GENERAL INSTRUCTIONS - this form needs to be completed only when a beneficiary wishes to have their Personal Health Information released to another person or organization, outside of routine treatment, payment and operations.

1. Please **PRINT** information in black pen so it is easy to read.
2. Do not skip any steps. Fill all information in as completely as possible.
3. When selecting the types of records you want disclosed, you may only check **ONE BOX PER FORM**. Each type will require a separate form, and each form must be completely filled out and signed.

SPECIFIC INSTRUCTIONS FOR FILLING OUT THE AUTHORIZATION

1. Beneficiary name – your name
2. Beneficiary street, city, state, zip – your address
3. Sponsor ID Number – the social security number of the military member
4. Beneficiary social security number – your social security number
5. Choose the type of record you are authorizing to be disclosed. **REMEMBER YOU CAN ONLY CHECK ONE BOX PER FORM.** Each additional request type will require a separate form.

   If you choose Mental Health Records or Alcohol & Drug Abuse Records, please fill in the Nature of Information section, and be as limited as possible. Use specific descriptions such as:
   - Claims information from _____ to _____
   - Records from _____ to _____
   - Appeal/review information from _____ to _____
   - All claims information
   - Complete record set
   - All appeal/review information

6. Information Disclosed to - State the complete proper name of the person or organization you are requesting receive your personal information, and their address.

7. Purpose for the disclosure – choose the reason for the information being disclosed:

Personal use	Insurance Claims
Continued medical care	Retirement/Separation
School	Legal

Other – If you choose “Other”, use specific descriptions such as:
- Evaluation of fitness for duty
- Case Management
- Coordination of Care

If signed by legal representative, please provide representative documentation as required by state law, i.e. Power of Attorney, Health Care Surrogate, Living Will or Guardianship papers. AFRM WILL NOT PROCESS INVALID FORMS.

8. Authorization Expiration Date – We recommend authorizing for no more than three (3) years in the future; however, any future date is accepted. If the expiration date is left blank, the authorization for release of information will be valid for one (1) year from the date the form was signed. PLEASE NOTE: If you are a minor child, the expiration date cannot exceed your eighteenth (18) birth date, at which time a new authorization will need to be completed, if desired.

9. You must sign and date the form.

10. If you are a parent/Court appointed guardian of a minor child, your signature is required together with that of the minor child. If you are a Court appointed guardian of a disabled adult or an authorized representative acting on behalf of a physician certified incapacitated beneficiary, your signature is required, as the beneficiary's authorized representative. A complete copy of any legal documents, and if applicable, a certified physician statement granting you the authority to act on this individual's behalf will need to be attached to the form.

Certain privacy protections have been put in place to protect patients when seeking health care services. Many state laws differ from one another concerning these privacy rules.

Various states allow a beneficiary, younger than age 18, to seek health care services regarding sensitive diagnosis; such as, Pregnancy and Birth Control, Abortion, AIDS and STDs, Mental Health and Alcohol and Substance Use, without the consent of a parent or Court appointed guardian.

Therefore, in order to speak with a parent or guardian about such services, an Authorization for Release of Information for Sensitive Diagnosis Only form **must** be signed and received from the beneficiary prior to any sensitive health information being disclosed.