ALPINE WOMEN'S CENTER

Semen Analysis

Patient Name (male):_____ Phone Number:_____

Partner Name (female):_____ Phone Number:_____

Patient (male) Information:

Insurance Company:_____

Insurance ID:_____ Insurance Group Number:_____

Date of Birth:_____ Social Security Number:_____

Mailing Address:_____

HIPAA DISCLOSURE AUTHORIZATION

Patient Name (male):_____

I hereby authorize _____ALPINE WOMEN'S CENTER_____ to use or disclose my protected health information related to _____SEMEN COLLECTION_____ to Partner Name (female):_____.

- I understand that I may inspect or copy the protected health information described by this authorization.
- I understand that, at any time, this authorization may be revoked, when the office that receives this authorization receives a written revocation, although that revocation will not be effective as to the disclosure of records whose release I have previously authorized, or where other action has been taken in reliance to an authorization I have signed. I understand that my health care and the payment for my health care will not be affected if I refuse to sign this form.

_____ _____

Signature of Patient (male) Date

EXPIRATION DATE: This authorization will expire on _____. If no date or event is stated, the expiration date will be six years from the date of this authorization.