PLUM

Authorization for Request of Health Information

PATIENT INFORMATION

Patient Name: **Date of Birth:**

_____ _____

Address: **City/State/Zip**

_____ _____

Phone: **Email:**

_____ _____

REQUESTING MEDICAL RECORDS FROM:

Provider:

_____

Facility Name:

_____

Attn:

_____

Address: **City/State/Zip**

_____ _____

Phone: **Fax:**

_____ _____

RECEIVING PARTY:
Plum Egg Donor Agency, LLC | 9205 W. Russell Rd. Building 3, Suite 240 | Las Vegas, NV 89148
Phone: 702-850-0698 |Fax: 702-988-8036 | Email: info@plumeggdonors.com
***** Preferred Delivery of Information: FAX TO 702-988-8036 *****

INFORMATION TO BE RELEASED

Date of Service: From _____ To _____

☐ Office Visits Consultations ☐ Psychological Evaluation ☐ Past Egg Donor Cycle Information/Records/Outcome/ Labs & Protocol ☐ Genetic Counseling Notes/Records ☐ Genetic Blood Test Results ☐ Pap Report, including biopsy report

SPECIAL AUTHORIZATION TO DISCLOSURE SUPER-CONFIDENTIAL INFORMATION

ALCOHOL/DRUG/INFECTIOUS DISEASE/MENTAL HEALTH RECORDS are protected by Federal Regulation 42CFR, Part 2. Release of such requires specific consent. I hereby grant such specific consent as signed below. I UNDERSTAND that these records are protected under federal and state law and cannot be disclosed without my written consent unless otherwise provided by the law. I further UNDERSTAND that the specific type of information to be disclosed may, if applicable, include diagnosis, prognosis, and treatment for physical and/or mental illness including treatment for alcohol or substance abuse, sexually transmitted diseases, acquired immune deficiency syndrome (AIDS), human immunodeficiency virus (HIV) infection.

PURPOSE OF DISCLOSURE | PATIENT REQUEST

I UNDERSTAND that this authorization will expire year from the date of signature below.

I UNDERSTAND that if I may revoke this authorization at anytime.

I UNDERSTAND that if I revoke this authorization, I must do so in writing and present my written revocation to the health information management department.

I UNDERSTAND that the revocation will NOT apply to information that has already been released in response to this authorization.

I UNDERSTAND that I may inspect or obtain a copy of the information to be used or disclosed, as provided in CFR 164.524.

I UNDERSTAND that any disclosure of information carries with it the potential for an unauthorized disclosure and the information may not be protected by federal confidentiality rules

If I have questions about disclosures of my health information, I can contact the authorized individual or organization making disclosure.

I have read the foregoing Authorization for Release of Health Information and do hereby acknowledge that I am familiar with and fully understand the terms and conditions of this authorization.

_____

Patient Name (Printed)

_____ _____

Patient Signature Date