Protected Health Information Authorization

Henry Fertility ***Michael A. Henry, M.D.***

I, _____

(Patient name) (Address)

_____

(City, state, zip code) (Date of birth)

request that the following options be followed for the disclosure of my Protected Health Information, (which would include your name, diagnosis, test results, and dates of service) as described in the Notice of Privacy Practices for Protected Health Information.

PLEASE LIST ALL THAT APPLY:

Henry Fertility may disclose information to the following persons (you must list name, phone number and relationship).

Name	Phone Number	Relationship

Email is our preferred method of contact.
If you prefer to be contacted by phone, please check here ____ Phone Number:_____

It is okay to contact and correspond via email at this address: _____

Henry Fertility may leave Protected Health Information on my answering machine/voicemail. Phone number (home, cell, work):

_____

_____

(Patient's Printed Name) (Social Security Number)

_____

(Patient's Signature) (Date)

I understand that I have the right to revoke this authorization, in writing, at any time by sending written notification to the Office Manager at Reproductive Care of Indiana.

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