Women's Health
ASSOCIATES

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Spouse / Partner Release of Information Authorization

In order to protect your privacy and comply with HIPPA regulations, we are not able to release your semen analysis or any other lab results to anyone but you, unless we have your written consent to do so. Therefore, in order to obtain your semen analysis or lab results from our office, please know you have two options available to you: 1) you can call the Primary Nurse for the ordering Physician to obtain your results, or 2) you can complete / return this form to our office and we will call your Spouse / Partner with the results.

Your Name (print)**:** _____ **Date of Birth:** _____

Address: _____ **Phone:** _____

☐ I authorize Women's Health Associates to leave any information on my voicemail at the number above.

☐ I do **NOT** authorize Women's Heatlh Associate to leave any information on my voicemail.

☐ I authorize Women's Health Associates to release my results to:

Name of Spouse / Partner (print)**:** _____
Date of Birth: _____
Spouse / Partner's Physician: _____

☐ I do NOT wish to release any personal, medical information to anyone other than myself.

I understand that I have the right to revoke this authorization at any time. 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 the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. **Unless otherwise revoked, this authorization will expire on the following date, event or condition (not to exceed one year)_____. If I fail to specify an expiration date, event or condition, this authorization will expire one year from the date signed.**

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. 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 re-disclosure and the information may not be protected by Federal confidentiality rules. If I have questions about disclosure of my health information, I can contact the individual or organization making the disclosure.

Signature: _____**Today's Date:** _____

Email completed form to info@secure.womenshealthkc.com or mail/fax (see below)

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