

REPRODUCTIVE CARE OF INDIANA

201 Pennsylvania Parkway, Suite 310
Indianapolis, IN 46280

PROTECTED HEALTH INFORMATION AUTHORIZATION

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, dates of service as described in the Notice of Privacy Practices for Protected Health Information.

PLEASE LIST ALL THAT APPLY:

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

Name	Phone Number	Relationship

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

Other: _____

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.