Advanced REPRODUCTIVE CENTER

CONSENT FOR VERBAL RELEASE OF INFORMATION

1. Please provide your email address and preferred phone contact information.

   Home: _____ Cell: _____ Work: _____

   Email: _____

2. Which phone number is best to use during the day (7am-5pm)? ◯ Home ◯ Cell ◯ Work

3. Representatives of Advanced Reproductive Center may leave detailed messages regarding appointments or send practice notifications using the information provided.

4. Check box if we may leave detailed lab/test results on your voicemail* ☐ Home ☐ Cell ☐ Work

   * Answering machines and voicemail must have an identifying message to confirm these are your numbers – for example, "You have reached Jane Doe."

   * Please list any persons with whom we MAY share details regarding your health care. Indicate below whether this may include sensitive health information (SHI) such as reproductive health information, HIV and other STD information and results, and/or genetic testing: For couples, list both intended parents if you wish information to be shared.

Name	Relationship	Release SHI?
		◯ Yes ◯ No
		◯ Yes ◯ No
		◯ Yes ◯ No

- I understand that this consent is valid until it is revoked by me. I understand that I may remove this content at any time by giving written notice of my desire to do so, to the physician or practice. I also understand that I will not be able to revoke this consent in cases where the physician has already relied on it to use or disclose my health information. Written revocation of consent must be sent to the physician's office.
- I understand my consent to the individual(s) who receives my medical/financial information is separate and distinct from Advanced Reproductive Center's use and disclosure of information described and permitted under the Notice of Privacy Practices, which has been provided to me.

Signature: _____ Date: _____

Printed Name: _____
(patient, parent or guardian)