

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

This Authorization for Release of Protected Health Information (“Authorization”) is voluntary and authorizes **Hanabusa IVF, Medical Corporation**, a California corporation (“Hanabusa IVF”) to disclose your protected health information in the manner indicated below. Please be aware that once your protected health information is released to other entities or individuals, Hanabusa IVF will no longer be able to protect that information, and the recipients of your information may not be legally required to protect your information.

1. Patient Information.

Patient Name _____ Address _____
 Date of Birth _____
 Phone _____ Email _____

2. Information to Be Released. This Authorization is limited to the following medical records and type of information:

- | | |
|---|--|
| <input type="checkbox"/> Complete Medical Record | <input type="checkbox"/> History/Physical Examination |
| <input type="checkbox"/> Diagnostic Tests | <input type="checkbox"/> X-Ray/Ultrasound Reports |
| <input type="checkbox"/> Doctor’s Notes | <input type="checkbox"/> Hospital and Surgical Reports |
| <input type="checkbox"/> Laboratory Tests and Results | <input type="checkbox"/> Images, such as photographs or videotapes |
| <input type="checkbox"/> IVF Laboratory Records | <input type="checkbox"/> Services from _____ to _____
(dates) |
| <input type="checkbox"/> Other: _____ | |

3. Sensitive Information. In addition to the above types of information, I hereby authorize Hanabusa IVF to release the following sensitive information:

- | | | | |
|--|-----------------|---|-----------------|
| <input type="checkbox"/> Mental Health Records | Initials: _____ | <input type="checkbox"/> Alcohol/Drug Abuse Records | Initials: _____ |
| <input type="checkbox"/> Genetic Tests Results | Initials: _____ | <input type="checkbox"/> Sexually Transmitted Disease (STD) Records | Initials: _____ |
| <input type="checkbox"/> HIV/AIDS Test Results | Initials: _____ | | |

4. Duration. I understand that this Authorization may be revoked in writing at any time, except to the extent that action has already been taken in reliance of this Authorization. Unless otherwise revoked, this Authorization will expire as follows:

- Specific Time Frame: _____
 When Records Are Received
 Other: _____

5. Receiving Party: Pursuant to the Health Insurance Portability and Accountability Act (“HIPAA”), I hereby authorize Hanabusa IVF to release the above protected health information to:

Self - or - Name _____ Phone _____
 Address _____ Fax _____
 Email _____

Delivery Preference: Pick Up Mail Fax Email

 Patient Printed Name Patient Signature Date