Acacio Fertility Center, Inc.
Brian Acacio, M.D.
27882 Forbes Road Suite 200 Laguna Niguel, CA 92677
Phone: (949)249-9200 Fax: (949)249-9203 Cell: (949) 201-9851

Mission Viejo Office
26800 Crown Valley Parkway Suite 560
Mission Viejo, CA 92691
Tel (949) 218-5981
Fax (949) 218-5982

Bakersfield Office
2205 19th Street
Bakersfield, CA 93301
Tel (661) 326-8066
Fax (661) 843-7706

AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient's Name: ______________________ Date of Birth: ______________________

Previous Name: ______________________ Social Security #: ______________________

I request and authorize ____

Phone/Fax Number ____

To release healthcare information of the patient named above to:

Name: Acacio Fertility Center

Address: 27882 Forbes Road, Suite 200

City: Laguna Niguel State: CA Zip Code: 92677

This request and authorization applies to:

☐ Healthcare information relating to the following treatment, condition, or dates: ______________

☐ All healthcare information

☐ Other: ____

Definition: Sexually Transmitted Disease (STD) as defined by law, RCW 70.24 et seq., includes herpes, herpes simplex, human papilloma virus, wart, genital wart, condyloma, Chlamydia, non-specific urethritis, syphilis, VDRL, chancroid, lymphogranuloma venereuem, HIV (Human Immunodeficiency Virus), AIDS (Acquired Immunodeficiency Syndrome), and gonorrhea.

☐ Yes ☐ No I authorize the release of my STD results, HIV/AIDS testing, whether negative or positive, to the person(s) listed above. I understand that the person(s) listed above will be notified that I must give specific written permission before disclosure of these test results to anyone.

☐ Yes ☐ No I authorize the release of any records regarding drug, alcohol, or mental health treatment to the person(s) listed above.

☐ Yes ☐ No This medical information may be used by the person I authorize to receive this information for medical treatment or consultation, billing or claims payment, or other purposes as I may direct.

☐ Yes ☐ No This authorization shall be in force and effect until _______________(date or event) at which time this authorization expires. It will expire in 90 days unless otherwise authorized.

☐ Yes ☐ No I understand that I have the right to revoke this authorization,in writing, at any time. I understand that a revocation is not effective to the extent that any person or entity has already acted in reliance on my authorization or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

☐ Yes ☐ No I understand that my treatment, payment, enrollment, or eligibility for benefits will not be conditioned on whether I sign this authorization

☐ Yes ☐ No I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected By Federal or state laws.

Patient Signature:____ Date Signed___________