

**Virginia IVF & Andrology Center
Supplemental Patient Information Form**

Patient Name _____ Date of Birth _____

New Patient: Complete all sections, sign in the last block

Repeat Patient: Do not complete form unless changes are desired

Disclosures to Family Members and Friends

Under HIPAA legislation, you as our patient, are the only person to whom we can release information related to your services or account (with the exception of any ordering physician or designated insurance company).

Do you wish to authorize Virginia IVF and Andrology Center to make disclosure of personal information to family or friends as may be needed for treatment or payment? Only information necessary and relevant to current treatment will be disclosed. This authorization will remain in effect unless revoked.

Please note that if your services are based on the order of a physician who is treating your partner, test results will be released to that physician. If you do not want disclosure of your results released to your partner, you must contact the ordering physician and put your request on file. Virginia IVF and Andrology Center cannot be responsible for the release of information occurring outside of our facility.

Individuals Authorized to Receive Information

Name _____ spouse/parent/other _____

Name _____ spouse/parent/other _____

Name _____ spouse/parent/other _____

Name _____ spouse/parent/other _____

Remove Individuals Previously Authorized to Receive Information

Name _____ spouse/parent/other _____

Name _____ spouse/parent/other _____

Name _____ spouse/parent/other _____

Patient Signature (changes only) _____ *Date* _____

Notice of Privacy Practices

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information (PHI) about you. As provided in our notice, the terms of our notice may change. If we revise our notice, you may obtain a revised copy.

I have received a copy of Virginia IVF & Andrology Center's Notice of Privacy Practices. I have had an opportunity to read the Notice of Privacy Practices. I understand that I may ask questions to the Center if I do not understand any information contained in the Notice of Privacy Practices.

Patient Signature _____ Date _____

If patient is not present:

Partner Signature _____ Date _____

VA IVF USE ONLY: *Notice mailed* *Notice given to partner* *Employee Initials*