

THE FERTILITY INSTITUTE OF VIRGINIA, LTD.
Supplemental Patient Information Form

Patient Name: _____ Date of Birth: _____

**New Patients: Please complete all sections and sign in the last block.
Repeat Patients: 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 The Fertility Institute of VA, Ltd. 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 until 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 to your partner, you must contact the ordering physician and put your request on file. The Fertility Institute of VA, Ltd. cannot be responsible for the release of information occurring outside of our office.

Individuals Authorized to Receive Information

Name: _____ Spouse/Partner/Other: _____

Name: _____ Spouse/Partner/Other: _____

Name: _____ Spouse/Partner/Other: _____

Remove Individuals Previously Authorized to Receive Information

Name: _____ Spouse/Partner/Other: _____

Name: _____ Spouse/Partner/Other: _____

Patient Signature (changes only): _____ Date: _____

Notice of Privacy Practices

Our Notice of Privacy Practices provides information about how we 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 The Fertility Institute of VA, Ltd.'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 Fertility Institute of VA, Ltd. 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: _____

FIV USE ONLY: _____ Notice mailed _____ Notice given to partner _____ Employee initials