Brian Acacio, M.D.

Laguna Niguel Office

27882 Forbes Road Suite 200 Laguna Niguel, CA 92677

Phone: (949)249-9200 **Fax: (949)249-9203**

Mission Viejo Office
26800 Crown Valley Parkway Suite 560
Mission Viejo, CA 92691
Tel (949) 249-9200
Fax (949) 949-9203

Bakersfield Office
2225 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 number: ____________________ Fax number: ____________________

To release healthcare information of the patient named above to:

Name: Acacio Fertility Center Phone: 949-249-9200 Fax: 949-249-9203

Address: 27882 Forbes Rd Suite 200

City: Laguna Niguel State: CA Zip Code: 92677

Please include email address if you would like to receive an electronic copy of your records.

EMAIL ADDRESS:____________________

This request and authorization applies to:

☐ All healthcare information **($30 fee if sent directly to patient)**

☐ 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: ____________________