Blue Sky Fertility

PATIENT CONSENT FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION

I have reviewed of Blue Sky Fertility's **NOTICE OF PRIVACY POLICIES** available at www.blueskyfertility.com), detailing how my information may be used and disclosed as permitted under federal law and state law. I understand the contents of the **NOTICE**, and I request the following restriction (s) concerning the use of my personal medical information:

_____

_____

_____

_____

I authorize the release of my medical information (protected health information) to the following:

1) Name _____ Relationship:_____ Date: _____

2) Name _____ Relationship:_____ Date: _____

3) Name _____ Relationship:_____ Date: _____

Further, I permit copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either myself or to the party who accepts assignment. Regulations pertaining to medical assignment benefits apply.

Signed: _____ Date:_____

If not signed by the patient, please indicate relationship to the patient.

Relationship: _____