# Authorization to Release
# Medical Information – Treatment Instructions - Prescriptions

**Your Name:** _____ DOB: _____

Partner name: _____ Partner DOB: _____

Insurance Co: _____ Pharmacy name & phone: _____

In order for us to contact you, please indicate all contact telephone numbers and circle your order of preference. We recommend allowing us to leave a message with one of your contact numbers. Please do not list a pager number.

Your home phone: _____ 1 2 3 4 May we leave a message? Yes No

Your work phone: _____ 1 2 3 4 May we leave a message? Yes No

Your cell phone: _____ 1 2 3 4 May we leave a message? Yes No

Alternate phone: _____ 1 2 3 4 May we leave a message? Yes No

May we release information to your Partner? Yes No Partner work phone: _____

Partner cell phone: _____

*I give my permission to Drs. Raymond Ke, William Kutteh, Paul Brezina,Amelia Bailey and the staff of Fertility Associates of Memphis and Memphis Fertility Laboratory to render medical care and treatment. I authorize the physicians or their staff to release information pertaining to my care to the above phone numbers, pharmacy, reference laboratories and consulting physicians. I understand that I have the right to withdraw this consent for the release of information at any time. Such withdrawal must be in writing. NO INFORMATION CAN BE RELEASED AFTER CONSENT HAS BEEN WITHDRAWN.*

**Signature of Patient/Guardian and Date:** _____

## Acknowledgement of <u>New Patient Packet</u> and of <u>Financial Responsibility</u>

*I am aware that every effort has been made to verify my insurance coverage for services provided by Fertility Associates of Memphis. I understand that services rendered may not be covered by my health insurance or other health benefit program. I understand that I must notify this practice if I have, or have applied for, any benefits from TennCare, State Medicaid, Medicare or Tricare. I agree to be financially responsible for any and all services rendered by Fertility Associates of Memphis including those denied as non-covered and any and all services rendered by Memphis Fertility Laboratory, prior to initiating treatment. I understand and accept responsibility for the terms and conditions outlined in the New Patient Packet. Furthermore, I acknowledge receipt and understanding of the New Patient Packet and all information included therein.*

**Signature and Date:** _____

## Acknowledgement of Receipt of <u>Notice of Privacy Practices</u>

*I have received a copy of Fertility Associates of Memphis's Notice of Privacy Practices as required by HIPAA Privacy Regulations effective 08/01/2017.*

**Signature and Date:** _____