

**MIDWEST REPRODUCTIVE CENTER, PA**

*~Privacy Statement~*

Dear Patient:

The Privacy Act of 1977 was designed to protect you. To give you a feeling of security, be assured that when you come into this office your medical and financial affairs will not be discussed without your permission. This means that your spouse, your personnel director, and even your parents have to have authorization signed by you before they may receive information regarding your medical care. It is against the law for the staff to give out this information without your written consent.

For those of you who wish for your spouse, social worker, personnel director, parents, etc., to call this office and receive information about you or about your bill, please print and complete the form below. In order for us to give out information, any one who calls in will have to provide our staff with your social security number, date of birth and a password which you will provide. If there is not anyone whom you would like to receive information about you, please draw a line through the bottom portion and sign and date it.

Social Security Number: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_

Thank you for your corporation in this matter.

I, \_\_\_\_\_, give permission for the staff of Midwest Reproductive Center, PA to release medical/billing information to my \_\_\_\_\_,  
(Relationship)

\_\_\_\_\_  
(Name)

I, \_\_\_\_\_, give permission for the staff of Midwest Reproductive Center, PA to release medical information to my \_\_\_\_\_,  
(Relationship)

\_\_\_\_\_  
(Name)

I, \_\_\_\_\_, give permission for the staff of Midwest Reproductive Center, PA to release medical information to my \_\_\_\_\_,  
(Relationship)

\_\_\_\_\_  
(Name)

**Patient Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_