

FAMILY AUTHORIZATION

Please Print Your Name (as the patient): _____

I hereby authorize Delaware Valley OB-GYN and Infertility Group, P.C. (the "Practice") to release my Patient Information described below to:

- All my family members
- Spouse
- Mother
- Father
- Children: _____
- Other Family Members: _____
- The following persons: _____
- You may leave all information on my voice mail, except: _____

Documents/Information to Be Released:

Purpose of Disclosure (explain or indicate "at the request of the individual"):

I understand that the Health Insurance Portability and Accountability Act of 1996, and its implementing regulations ("HIPAA") govern the terms of this Authorization. I understand that I have the right to revoke this Authorization, at any time prior to the Practice's compliance with the request set forth herein, provided that the revocation is in writing. I further understand that additional information relating to the exceptions to the right to revoke and a description of how I may revoke this authorization is set forth in the Practice's Notice of Privacy Practices. I understand that any revocation must include my name, address, telephone number, date of this Authorization and my signature and that I should send it to:

**Delaware Valley OB/GYN and Infertility Group, P.C.
2 Princess Rd., Suite C
Lawrenceville, NJ 08648**

Attn: Privacy Officer – Astrid Rubin

I understand that I am not required to sign this authorization and that the Practice may not condition treatment on my execution of this authorization.

I understand that the information used or disclosed pursuant to this authorization may be subject to re-disclosure by the Recipient listed above and, in that case, will no longer be protected by HIPAA.

This authorization expires upon [cessation of treatment; release from hospital; birth of child; conclusion of course of treatment].

I hereby acknowledge receipt of a copy of this Authorization.

Signature of Individual or Personal Representative

Description of Personal Representative's Authority

Date of Authorization