UNIVERSITY OF WASHINGTON MEDICAL CENTER
MALE FERTILITY CLINIC AND LABORATORY
Authorization to Use and Disclose Health Information

I ______________________________ (U#______________) authorize the University of Washington Medical Center, Male Fertility Clinic and Male Fertility Laboratory to use and to disclose health information relating to my fertility evaluations and frozen sperm (if applicable), which may include identifying information about my health condition and treatment, to *[Program name]* ______________________ ______________ ("Receiving Program") located at: *[Address of Receiving Program]*

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The purposes of such use and disclosure are to transfer my care and treatment to the Receiving Program, to promote the appropriate transportation, storage, and disposition of my frozen sperm (if applicable), and for payment and operational purposes.

I specifically recognize and authorize that the information listed below may be used, disclosed, or received under this authorization:

- Mental health
- Genetic testing
- Drug and/or alcohol abuse diagnosis, treatment, or referral
- HIV / AIDS / Sexually transmitted diseases

1. If the Receiving Program is not a health plan or provider covered by federal or state privacy laws, then the information used, disclosed, and received under this authorization may be subject to redisclosure and no longer protected by those laws. Federal or state law, however, may restrict redisclosure of HIV/AIDS/STDs, mental health, genetic testing, and drug/alcohol abuse diagnosis, treatment, or referral information.

2. I may refuse to sign this authorization. My refusal will not adversely affect my ability to receive treatment from the University of Washington, payment for services by my health plan, enrollment in a health plan, or eligibility for health plan benefits. I understand that the Receiving Program may need the information for the purposes listed above.

3. I may revoke this authorization at any time by notifying UW Medicine Privacy Office, Box 359210, Seattle, WA 98195, except to the extent that action has been taken in reliance upon this authorization.

4. Unless revoked, this authorization is limited to the following time period:

Commencing: The date of this authorization.

Ending: After the completion of the transfer of my frozen sperm and related events, not to exceed 90 days for information relating to care received after the date of this authorization.

5. I received a copy of this authorization. I may inspect or request copies of information disclosed by this authorization.

SIGNATURE: I have read this authorization, I understand it, and I have had an opportunity to have any questions answered to my satisfaction.

____ Date: ____________________

Signed