



Idaho Center for Reproductive Medicine

111 Main Street Suite # 100 / Boise, ID 83702 / (208) 342-5900

Request for Confidential Communication of Protected Health Information

I, _____, give ICRM permission to disclose medical
(Patient's name –please print)

information and/or test results to _____.
(Partner's name, other family member, etc. – please print)

Please list the relationship to the patient: _____.

(Patient's Signature)

(Date)

I, _____, give ICRM permission to disclose medical
(Partner's name –please print)

information and/or test results to _____.
(Patient's name, other family member, etc. – please print)

Please list the relationship to the partner: _____.

(Partner's Signature)

(Date)

Your records are considered protected health information (PHI) and we will not release any information without your consent and signature.