Idaho Center for Reproductive Medicine

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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.