## **Authorization To Release Medical Information** to Spouse / Partner



Welcome to Advanced Reproductive Center of Hawai'i. Please take a moment to provide the information requested below so our team can better serve you.

By signing below I hereby give my permission to Dr. Christopher Huang, Dr. Christina Arnett, and the Advanced Reproductive Center of Hawai'i staff to disclose my medical information, for any reason, to my spouse/partner listed below.

Unless I specify below under "Exclusion", I acknowledge that this includes any health information relating to testing, diagnosis and treatment for: AIDS/HIV, Sexually Transmitted Diseases, Alcohol/Drug Use and Developmental Disabilities.

This agreement will remain in effect until I advise the Advanced Reproductive Center of Hawai'i in writing.

PATIENT NAME	PATIENT SIGNATURE	DATE
SPOUSE / PARTNER NAME	SPOUSE / PARTNER SIGNATURE	DATE
Exclusion		
/ Initial here if you DO NOT authorize the release of any health information relating to testing, diagnosis and treatment for: AIDS/HIV, Sexually Transmitted Diseases, Alcohol/Drug Use and Developmental Disabilities.		