



**\*\*\*AFTER COMPLETING THIS FORM-SEND IT TO YOUR CURRENT OR FORMER  
PHYSICIAN \*\*\***

\*\*\*\*\*

**INFORMED CONSENT FOR DISCLOSURE OF PATIENT HEALTH CARE  
INFORMATION**

I, \_\_\_\_\_  
(Patient First Name) (Last Name) (Date of Birth) (Maiden Name)

authorize \_\_\_\_\_  
to disclose to:

**Dr. K Paul Katayama  
Advanced Institute of Fertility  
2801 W. Kinnickinnic River Pkwy, Ste 535  
Milwaukee, WI 53215  
TEL: (414) 645-5437  
FAX: (414) 645-5401**

information from my health care record. I understand that the specific type of information to be  
disclosed includes: \_\_\_\_\_ and  
that this disclosure is being made for the following purpose(s): \_\_\_\_\_

In compliance with State Statues, which require special permission to release otherwise privileged  
information; I authorize release of records pertaining to:

- HIV (AIDS)       Drug Abuse       Alcoholism  
 Mental Health       Other: \_\_\_\_\_

This consent is effective for one (1) year from the date signed, or until revoked in writing as per our  
Notice of Privacy Practices. Information disclosed pursuant to this authorization may be re-disclosed  
by the recipient and no longer protected by the privacy rule. A photocopy is as valid as the original.

\_\_\_\_\_  
Signature of Patient

\_\_\_\_\_  
Date