



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 _____.

Please list the relationship to the patient: _____.

(Patient's Signature)

(Date)

I, _____ give ICRM permission to disclose medical
(Patient's Name - Please Print)

information and/or test results to _____.

Please list the relationship to the patient: _____.

(Patient's Signature)

(Date)