

**PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH
INFORMATION (PHI)**

**The Fertility Center, LLC
130 Leader Heights Road
York, PA 17403
717-747-3099**

With my consent, _____ The Fertility Center, LLC _____ may use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). Please refer to the Notice of Privacy Practices for a more complete description of such uses and disclosures.

I have the right to review the Notice of Privacy Practices prior to signing this consent. The Fertility Center, LLC reserves the right to revise its Notice of Privacy Practices at anytime. A revised Notice of Privacy Practices may be obtained by forwarding a written request to The Fertility Center, LLC at 130 Leader Heights Road in York, PA 17403.

With my consent, _____ The Fertility Center, LLC _____ may call my home or other designated location and leave a message on voice mail or in person. This message must be in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any call pertaining to my clinical care, including laboratory results among others.

With my consent, _____ The Fertility Center, LLC _____ may mail to my home or other designated location any items that assist the practice in carrying out TPO, such as appointment reminder card and patient statements. These items must be marked Personal and Confidential.

With my consent, _____ The Fertility Center, LLC _____ may e-mail to my home or other designated location any items that assist the practice in carrying out TPO, such as appointment reminders and patient statements. I have the right to request that _____ The Fertility Center, LLC _____ restrict how it uses or discloses my PHI to carry out TPO. However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to _____ The Fertility Center, LLC _____'s use and disclosure of my PHI to carry out TPO.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, _____ The Fertility Center, LLC _____ may decline to provide treatment to me.

Signature of Patient (or parent and/or guardian)

Date

Print Name of Patient or Legal Guardian

Date

Witness of Signature

Date