The Fertility Center

William Dodds MD, James Young MD,
Valerie Shavell MD, Mili Thakur MD, and Richard Leach MD

Notice of Privacy Practices: I acknowledge that I have been offered a copy of the Notice of Privacy Practices: _____
patient initials

Right to revoke or terminate: As stated in our Notice of Privacy Practices, you have the right to revoke or terminate this authorization by submitting a written request to our Privacy Manager. You may revoke an authorization at any time, in writing, except to the extent that your Healthcare Provider or the practice has taken an action in reliance on the use or disclosure indicated in the authorization.

Limited Patient Authorization for Disclosure of Protected Health Information to an Individual

(Please print all information. Authorization is in effect for 12 months with a mandatory requirement of updating annually, unless an earlier termination date is specified. (see below)

Patient Name: _____ **Partner to:** _____
'Patient' refers to the person completing this form

Patient Social Security Number: _____ **Patient Date of Birth:** _____

Purpose of request (who will be authorized to receive information) - I authorize ***the practice (identified below)*** to disclose or provide protected health information, about me to the individual(s) listed below.

Practice Name: Michigan Reproductive and IVF - dba – The Fertility Center

Who will be authorized to receive information (list each family member, friend, or other individual to receive PHI)**:**

Name:_____ Phone:_____ Relationship: _____

Name:_____ Phone:_____ Relationship: _____

Description of information to be disclosed - I authorize the practice to disclose the following protected health information about me to the entity, person, or persons identified above:

☐ **Entire patient record; or check only those items of the record to be disclosed**:

☐ office notes ☐ lab results ☐ x-rays; hospital ☐ financial history report (previous 3 years only).

☐ record of HIV and communicable disease testing ☐ record of mental health or substance abuse treatment

Purpose of disclosure (please check patient request or record the purpose of the disclosure)**:**

☐ Patient Request ☐Other (please specify): _____

Expirations or termination of authorization: This authorization will expire 12 months from the date of your last signature below, unless you specify an earlier termination. You must renew or submit a new authorization after the date of your last signature to continue the authorization. You have the right to terminate this authorization at any time. You must notify our privacy manager, in writing, if you decide to terminate the authorization prior to the normal expiration date. ***Please list date of expiration if earlier than 12 months from date of last signature)***: _____.

Non-Conditioning statement: The practice places no condition to sign this authorization on the delivery of healthcare or treatment.

Redisclosure: We have no control over the person(s) you have listed to receive your protected health information. Therefore, your protected health information disclosed under this authorization will no longer be protected by the requirements of the Privacy Rule and will no longer be the responsibility of the practice. (You have the right to receive a copy of signed authorizations upon request.)

_____ _____(expires in 12 months)
patient signature date

The Fertility Center

William Dodds MD, James Young MD,
Valerie Shavell MD, Mili Thakur MD, and Richard Leach MD

CONSENT FOR TREATMENT

Knowing that I require diagnostic testing, medical treatment or hospitalization, I voluntarily consent to the medical treatment deemed necessary in the judgment of my treating physicians. I am aware that the practice of medicine and surgery is not an exact science, and I acknowledge that no guarantees have been made to me regarding the results of examination, tests, or treatments. I understand that if major diagnostic studies or treatment procedures such as surgery are required, I will be asked to give specific consent to those procedures. If I am an obstetrical patient, I understand that my signature consents to the care and treatment of my fetus.

MY MEDICAL INFORMATION

I understand that The Fertility Center will keep my medical information according to state law, federal law, and policy. I also understand that my information will be stored electronically and may be sent to or received from other healthcare providers and/or payers electronically. This includes treatments and medicine or prescription information about me, including drug or alcohol use. In some cases, The Fertility Center is required by law to report information to an agency like the health department. This may prevent other diseases. I understand I can ask additional questions before signing this consent.

I have read the above information or have had it explained to me, and indicate my understanding of same, by signing this document.

**Please note: 'Patient Name' refers to the person completing this form.*

_____ _____ _____
Patient Name (Please Print) Patient Signature Date

_____
Current Fertility Center Patient (Spouse/Partner – Please Print)

_____ _____
The Fertility Center Staff Witness Date

If this consent form is not signed in the presence of a member of The Fertility Center staff, form **must be notarized below:*

Notary Public _____ County, Michigan
Acting in the County of _____
Signature _____
My commission expires:

The Fertility Center

William Dodds MD, James Young MD,
Valerie Shavell MD, Mili Thakur MD, and Richard Leach MD

CONSENT FOR HIV TESTING

HIV (Human Immunodeficiency Virus) infection is a long-term illness that damages the body's immune system and its ability to fight diseases. HIV can cause AIDS (Acquired Immunodeficiency Syndrome), the stage of HIV when the body is weakened and less able to fight off germs. HIV spreads through blood, semen, vaginal fluids, and breast milk. You can get or give an HIV infection by having vaginal, anal, or oral sex without a condom or sharing needles or works when injecting drugs. An infected mother can pass HIV to her child during pregnancy, birth or breastfeeding. You cannot get HIV by donating blood or through casual contact like hugging or shaking hands.

People can have HIV for years and not know it unless they get tested. If you **are infected**, it can help you get proper treatment and learn how to avoid spreading HIV to other people. If you **are not infected**, it can help you learn how to reduce your risk of getting HIV.

HIV testing: A **negative result** means you are not infected with HIV or you have a recent infection, too early to show up positive. If you have been exposed to HIV in the last six weeks, the test may not detect a new infection. A **positive result** means you are living with HIV. This means you can pass your infection to others through sex, sharing needles, through birth or breastfeeding. You should take precautions to avoid infecting others.

I understand I can ask additional questions before signing this consent and may ultimately refuse to sign it. My physician will review my treatment options at The Fertility Center, should I refuse HIV testing. I understand HIV test results are confidential and shall not be released without my permission, except as permitted under state law. I understand that I have a right to have this test done without the use of my name at any Michigan Department of Health-approved HIV counseling and testing site.

I acknowledge that I have been given an explanation of the test, including its uses, benefits, limitations, and the meaning of test results. I understand that I have the right to withdraw my consent for the test at any time before the test is complete. By my signature below, I consent to be tested for HIV.

☐ I consent to HIV Testing.
☐ I do not consent to HIV Testing

_____ _____
Patient Signature Date

**Please Note: Our credentialing agencies require that all In Vitro Fertilization (IVF) patients complete this test.*

I have read the above information or have had it explained to me, and indicate my understanding of same, by signing this document.

**Please note: 'Patient Name' refers to the person completing this form.*

_____ _____ _____
Patient Name (Please Print) Patient Signature Date

_____
Current Fertility Center Patient (Spouse/Partner – Please Print)

_____ _____
The Fertility Center Staff Witness Date

If this consent form is not signed in the presence of a member of The Fertility Center staff, form **must be notarized below:*

Notary Public _____ County, Michigan
Acting in the County of _____
Signature _____
My commission expires:

Patient Label

The Fertility Center

ZIKA ACKNOWLEDGEMENT
Possible Zika Exposure

Patient Name: _____ ("Patient") Date of Birth: _____

Partner Name: _____ ("Partner") Date of Birth: _____

The purpose of this document is to confirm that The Fertility Center, PC (The Fertility Center) has provided Patient (and Partner, if any) with information regarding Zika virus disease (Zika) and concerns about possible exposure to Zika during, or when planning for, pregnancy.

1. Zika is a disease caused by the Zika virus, which is spread to people primarily through the bite of an infected mosquito, but which can also be transmitted sexually through semen from infected males to sexual partners. Additional information about Zika, its symptoms, treatment and prevention, and various travel advisories issued by the United States Centers for Disease Control and Prevention (CDC), can be found at the following website: www.cdc.gov/zika.
2. It is not known whether infected men who never develop symptoms can transmit Zika virus to their sex partners. Sexual transmission of Zika virus from infected women to their sex partners has not been reported. Sexual transmission of Zika and many other infections, including those caused by other viruses, is reduced by consistent and correct use of condoms.
3. The most common symptoms of Zika are fever, rash, joint pain, and conjunctivitis (red eyes). Zika illness is usually mild with symptoms lasting for several days to a week. For this reason, many people may not realize that they have been infected.
4. **A Zika virus infection during pregnancy can cause a serious birth defect called microcephaly, as well as other severe fetal brain defects.** Additional information about microcephaly can be found on the CDC website at www.cdc.gov/ncbddd/birth defects/microcephaly. html.
5. As of November 2016, the majority of the regions affected by Zika are in Central and South America, but mosquito-borne spread of Zika also has been identified in areas of South Florida, as well as the Caribbean, including Puerto Rico. Please refer to the CDC website and Travel Heath Notices for an up to date list of places with Zika outbreaks: http://wwwnc.cdc.gov/travel/page/Zika-travel-information. It **is important to refer to the CDC website if the Patient or Partner is considering travel because the situation is constantly evolving.**
6. **The CDC has issued guidance for pregnant women, and women thinking about becoming pregnant.** Please see www.cdc.gov/Zika/specific-groups.html. The CDC and the American Society for Reproductive Medicine (ASRM) have also issued guidelines for US health care providers caring for pregnant women and women of reproductive age during active Zika virus transmission. The Fertility Center follows these guidelines and strongly encourages Patient (and Partner, if any) to continually monitor the CDC guidance if pregnant or planning to become pregnant.
7. **Based upon the information available regarding the risk to the unborn child and to patients, the physicians at The Fertility Center strongly advise Patient and any Partner NOT to travel to countries or areas with active Zika transmission while attempting pregnancy. Failure to comply with this advice may result in a delay of Patient's treatment.**
8. If Patient (or Partner, if any) has recently traveled to an area with active transmission of Zika virus, or has had sex *without* a condom with a man who has recently traveled to an area with active transmission of Zika virus or is infected with Zika, The Fertility Center will recommend that Patient wait to attempt pregnancy according to the timeframes currently suggested by the CDC and ASRM.

ACKNOWLEDGEMENT. By signing below, Patient (and Partner, if any) acknowledges having read and understood this ZIKA ACKNOWLEDGEMENT, including:

- the risks of Zika virus infection with respect to becoming pregnant and potential birth defects;
- the importance of consulting the CDC website for up-to-date information on Zika and affected areas; and
- The Fertility Center recommendations regarding planning pregnancy and infertility treatment for individuals infected, exposed, or possibly exposed to Zika virus.

Signature Page Follows

Patient Label

The Fertility Center

ZIKA ACKNOWLEDGEMENT
Possible Zika Exposure

A signature affirms that the signing individual has read this document and had all questions related to the document answered to the individual's satisfaction.

SIGNATURE(S):

Patient Printed Name	Patient Signature	Date	Time

Witnessed by The Fertility Center clinical staff member (photo ID of Patient required):

Printed Name of Staff Member	Signature of Staff Member	Date	Time

Notary required if consent <u>not</u> witnessed by and photo ID not presented to The Fertility Center clinical staff member:

STATE OF _____,

COUNTY OF _____ SS.: _____

On this _____ day of _____, 20_____, before me personally came

_____ to me known and known to me to be the person described in and who executed the foregoing instrument and he/she acknowledged to me that he/she executed the same.

_____
Notary Public

Partner Printed Name	Partner Signature	Date	Time

Witnessed by The Fertility Center clinical staff member (photo ID of Patient required):

Printed Name of Staff Member	Signature of Staff Member	Date	Time

****

I have consulted with and explained the contents of this document to the patient and (where applicable) the patient's spouse/ sexually intimate partner.

All question(s) concerning the procedures have been answered.

Physician Printed Name	Physician Signature	Date	Time