Boston IVF

ASSIGNMENT OF BENEFITS AND CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

NOTICE OF PRIVACY PRACTICES:
With this Form you have been provided with a copy of our Notice of Privacy Practices which provides a full description of how we will use and disclose your individually identifiable health information, including uses and disclosures for treatment, payment, and health care operation purposes. This Notice also explains important rights you have regarding your health information. Boston IVF Inc. and IVF New England (hereinafter referred to as the "Practice") reserves the right to change its Privacy Notice at any time but you may always obtain a current copy upon request or by going to our website: www.bostonivf.com.

USE AND DISCLOSURE OF INFORMATION:
As described in our Notice of Privacy Practices, we will use and disclosure your individually identifiable health information for a variety of treatment, payment and health care operations purposes. As part of your treatment, we expect that you will want and allow us to share, without restriction, all of your health information related to the treatment of you and your partner. Unless you specify any restrictions in the space provided below, you are hereby consenting to such treatment-related disclosures to your reproductive partner while you are undergoing treatment by our Practice. **The disclosure of your information may be made via mail, telephone, fax, e-mail, and/or Internet as may be necessary for the Practice to complete these purposes**. If your health information contains any privileged or additionally protected information under State or Federal law you will be asked to sign a specific authorization for the release of this information.

ASSIGNMENT OF BENEFITS:
In consideration for services and treatment rendered, I hereby assign, transfer, and set over onto the Practice all health insurance. I hereby direct my insurance company to make all payments for treatment and testing provided by Boston IVF Inc. and IVF New England to be sent directly to the Practice.

RESTRICTIONS ON USES AND DISCLOSURES:
As explained in our Notice of Privacy Practices, you have the right to request how the Practice uses and discloses your health information for the purposes of treatment, payment and health care operations, and disclosures to family members or friends. You also have the right to ask us to send communications including your health information to an address of your choice or that we communicate with you in a certain way (e.g. do not leave messages on my home answering machine). While we are not required to grant any such request, you may indicate your desired restrictions or instructions:

_____

Boston IVF

ASSIGNMENT OF BENEFITS AND CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

I hereby give consent to the Practice, and its professionals, employees and agents, to use and disclose my individually identifiable health information as described above. I hereby acknowledge that I have received a copy of the Practice's Notice of Privacy Practices. I understand that I can contact the Practice Privacy Officer at 781-434-6500 if I have further questions or any complaints. I hereby release Practice, its professionals, employees, and agents, from all liability arising from the use and disclosure of my health information for treatment, payment, and operations purposes. I understand that I may revoke this consent in writing except to the extent the Practice has already taken actions in reliance on it. I understand that if I revoke this consent, the Practice may refuse to provide me with further treatment. I also understand that this consent authorizes the Practice to use and disclose all past information documented in my medical record in accordance with its Privacy Notice.

_____ _____

Patient/Guardian Signature Relationship

TO BE FILLED OUT IF UNABLE TO OBTAIN WRITTEN ACKNOWLEDGMENT OF RECEIPT OF NOTICER OF PRIVACY PRACTICES FROM PATIENT

I attempted to obtain a written acknowledgment of receipt of the Practice Notice of Privacy Practices from the above named patient, but was unable to because:

Check the appropriate box:

☐ Patient declined to sign the Written Acknowledgment.
☐ Other [specify details] _____

By: ---------- Date: June 21, 2018