NW FERTILITY CENTER

Patient Consent for Use and Disclosure Of Protected Health Information (HIPAA)

I hereby give my consent for NW Fertility Center to use and disclose protected health information about me to carry out treatment, payment and healthcare operations. (NW Fertility Center's Notice of Privacy Practices provides a more complete description of such disclosures.)

I have the right to review the Notice of Privacy Practices prior to signing this consent. NW Fertility Center reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to NW Fertility Center's Privacy Officer at 1750 SW Harbor Way, Ste 200, Portland, OR 97201.

With this consent, NW Fertility Center may **call** my home or alternative location and leave a message on voice mail, or in person, in reference to any items that assist in the practice carrying out treatment, payment, and healthcare operations, such as appointment reminders, insurance items, and any calls pertaining to my clinical care, including laboratory results, among others.
With this consent, NW Fertility Center may **mail** to my home or other alternative location any items that assist in the practice in carrying out treatment, payment, and healthcare operations, such as appointment reminder cards, and patient statements.
With this consent, NW Fertility Center may **email** to my home or other alternative location any items that assist the practice in carrying out treatment, payment, and healthcare operations, such as appoint reminders, and test results.

I have the right to request that NW Fertility Center restrict how it uses or discloses my personal health information to carry out treatment, payment, and healthcare operations. However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

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, or later revoke this consent, NW Fertility Center may decline to provide treatment to me.

_____ _____
Printed Name of Patient Printed Name of Spouse

_____ _____
Signature of Patient or Legal Guardian Signature of Spouse

_____
Date