

## PREIMPLANTATION GENETIC DIAGNOSIS HIPAA CONSENT FORM

Patient Name: \_\_\_\_\_ D.O.B.: \_\_\_/\_\_\_/\_\_\_  
(Print)

I hereby authorize the staff of CNY Fertility Center to disclose my health information to Reprogenetics and their respective staffs for the purpose of performing a Preimplantation Genetic Diagnosis (PGD) procedure and resulting pregnancy and childbirth follow-up.

I authorize information to be forwarded prior to my IVF cycle to allow for proper preparation for the analysis. This authorization is limited in time to approximately twelve months from the date of my IVF cycle, Starting From: \_\_\_/\_\_\_/\_\_\_ . This authorization will automatically expire three months following childbirth unless otherwise specified.

Information to be disclosed will be limited to:

- ▲ Patient demographic information
- ▲ Preimplantation genetic diagnosis related information
- ▲ Previous history of infertility and pregnancy
- ▲ Genetic history including karyotype and other related testing
- ▲ IVF stimulation information and progress
- ▲ Embryology records of IVF procedure
- ▲ Embryo transfer and pregnancy testing results
- ▲ Gestation and childbirth results
- ▲ Genetic test results (if applicable) of product of conception
- ▲ Child information and genetic follow-up if available

It is my intent that the use of the information provided is prohibited for any purpose other than stated above, and that the information may not be disclosed to any other party to whom disclosure is not necessary or required for the purposes stated above.

I understand that I reserve the right to revoke this authorization at any time and that this must be done in writing and presented to an office staff member of CNY Fertility Center. I understand that this revocation will not apply to the extent that CNY Fertility Center has already taken action in reliance on this authorization.

I understand that authorizing the disclosure of this health information is a voluntary but necessary step for the conduct of my PGD procedure. I understand that I may obtain a copy of the information to be used or disclosed. I understand that this information may be inspected by the United States Food and Drug Administration or other governmental surveillance organization. I understand that any disclosure of information carries with it a potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules. If I have any questions about disclosure of my health information, I can contact CNY Fertility Center.

Patient Signature: \_\_\_\_\_ Date: \_\_\_/\_\_\_/\_\_\_

Witness Name: \_\_\_\_\_ Date: \_\_\_/\_\_\_/\_\_\_

Witness Signature: \_\_\_\_\_