Consent for Purposes of Treatment, Payment and Healthcare Operations

I consent to the use or disclosure of my protected health information by **Virginia Center for Reproductive Medicine** for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills, or to conduct health care operations of **Virginia Center for Reproductive Medicine**. I understand that diagnosis or treatment of me by **Fady I. Sharara, M.D** may be conditioned upon my consent as evidenced by my signature on this document.

I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment, or healthcare operations of the practice. **Virginia Center for Reproductive Medicine** is not required to agree to the restrictions that I may request. However, if **Virginia Center for Reproductive Medicine** agrees to a restriction that I request, the restriction is binding on **Virginia Center for Reproductive Medicine** and **Fady I. Sharara, M.D**.

I have the right to revoke this consent, in writing, at any time, except to the extent that **Fady I. Sharara, M.D** or **Virginia Center for Reproductive Medicine** has taken action in reliance on this consent.

My "protected health information" means health information, including my demographic information, collected from me and created or received by my physician, another health care provider, a health plan, my employer or a health care clearinghouse. This protected health information relates to my past, present or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I understand I have a right to review **Virginia Center for Reproductive Medicine** 's Notice of Privacy Practices prior to signing this document. The **Virginia Center for Reproductive Medicine** 's Notice of Privacy Practices has been provided to me. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills, or in the performance of health care operations of the **Virginia Center for Reproductive Medicine**. The Notice of Privacy Practices for **Virginia Center for Reproductive Medicine** is also provided at **11150 Sunset Hills Rd, Suite 100, Reston, VA 20190** and on the **VCRM**'s website at www.vcrmed.com. This Notice of Privacy Practices also describes my rights and the **Virginia Center for Reproductive Medicine** 's duties with respect to my protected health information.

Virginia Center for Reproductive Medicine reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised notice of privacy practices by accessing the **Virginia Center for Reproductive Medicine** 's website, calling the office and requesting a revised copy be sent in the mail, or asking for one at the time of my next appointment.

_____
Signature of Patient or Personal Representative

_____
Name of Patient or Personal Representative

_____
Date

_____
Description of Personal Representative's Authority