Island Reproductive Services
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Consent to Treat and Release of Information

The term "health care provider" in this document means Eric Knochenhauer M.D. or Michael Traub M.D., their agent(s) and employees, members of the medical staff, their agents and employees and other health care practitioners who provide care to patients.

I understand that as part of my health care, this organization originates and maintains health records describing my health history, symptoms, examinations, test results, diagnoses, treatments and any plan for care including future treatment. I understand that this information serves as:

- Basis for planning my treatment and care
- Information used to file my claim with the insurance company (diagnosis and procedure)
- Means by which a third-party payer can verify that billed services were actually provided
- A toll for routine health care operations including assessing quality and reviewing competency of your staff and/or health care providers

I understand that I have been provided with the Notice of Privacy that provides more complete information of uses and disclosures. I further state I have been given a copy of the Notice of Privacy prior to signing this consent. I understand that Island Reproductive Services reserves the right to change their notice and practices and will provide a copy of the changed form to me prior to treatment. At that time I will be required to sign a new consent before receiving any services. I understand I have the right to restrict how my health information may be used or disclosed to carry out payment, treatment or health care operation and that Eric Knochenhauer M.D. / Michael Traub M.D. are not required to agree to the restrictions requested. I understand that I have the right to revoke this consent in writing, except to the extent in my care to administer such examination, treatment, testing and procedures as are deemed necessary in the course of my care. We will disclose your protected health information without your verbal authorization per individual circumstance only with your prior written authorization which you may fill in below.

I authorize the release of my protected health information with regard to the minimum necessary policy, to the following individual(s):

____ **Relationship** _________________________________

____ **Relationship** _________________________________

Information necessary to substantiate my insurance claims may be released by the health care provider in my care.

________________________ ________________________ _________________
Signature Printed Name Date

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