USC
UNIVERSITY
OF SOUTHERN
CALIFORNIA

Keck School of Medicine
University of Southern California

PATIENT AUTHORIZATION TO SHARE MEDICAL INFORMATION

PATIENT NAME: _____

DATE OF BIRTH: _____

PARTNER NAME: _____

DATE OF BIRTH: _____

MEDICAL RECORD NUMBER: _____

DATE: _____

WHO MAY WE SHARE MEDICAL INFORMATION WITH? CHECK BOX AND PRINT FULL NAME.

- ☐ SPOUSE: _____
- ☐ PARTNER: _____
- ☐ CHILDREN: _____
- ☐ OTHER: _____

WHERE MAY WE LEAVE MEDICAL INFORMATION?

- ☐ TELEPHONE ANSWERING MACHINE/HOME
- ☐ FAX
- ☐ OFFICE
- ☐ EMAIL

SIGNATURE OF PATIENT: _____

SIGNATURE OF PARTNER: _____

USC Fertility
Alternatives for Today & Tomorrow

1127 Wilshire Boulevard, Suite 1400
Los Angeles, CA 90017

Tel: 213-975-9990
Fax: 213-975-9997

USCFertility.org

# HEALTH SCREENING DISCLAIMER

The USC Fertility clinic aims to provide individualized advanced reproductive care. Our care does not substitute for annual pelvic exams, breast exams, pap smears, mammograms, cholesterol screenings, fecal occult blood tests, sigmoidoscopies, and other tests. Our office does not provide information regarding gynecologic cancers, which is mandated by law to be a part of every woman's annual gynecological examination.

Your signature below confirms that you have read the above statement, that you understand that care in our office does not substitute for regular visits to your own physician and that it is your own responsibility to obtain periodic health screening tests and exams.

_____ _____

Signature of patient Date

# USC PATIENT EMAIL CONSENT FORM

To address the risks of using email

Patient name: _____
Patient address: _____
Email: _____
Provider: _____

1. RISK OF USING EMAIL

Transmitting patient information by email has a number of risks that patients should consider before using email. These include, but are not limited to, the following risks:

a) Email can be circulated, forwarded, stored electronically and on paper, and broadcast to unintended recipients.
b) Email senders can easily misaddress an email.
c) Backup copies of email may exist even after the sender or the recipient has deleted his or her copy.
d) Employers and on-line services have a right to inspect email transmitted through their systems.
e) Email can be intercepted, altered, forwarded, or used without authorization or detection.
f) Email can be used to introduce viruses into computer systems.
g) Email can be used as evidence in court.
h) Emails may not be secure, including at USC, and therefore it is possible that the confidentiality of such communications may be breached by a third party.

2. CONDITIONS FOR THE USE OF EMAIL

Providers cannot guarantee but will use reasonable means to maintain security and confidentiality of email information sent and received. Providers are not liable for improper disclosure of confidential information that is not caused by Provider's intentional misconduct. Patients must acknowledge and consent to the following conditions:

a) **Email is not appropriate for urgent or emergency situations. Provider cannot guarantee that any particular Email will be read and responded to within any particular period of time.**
b) Email must be concise. The patient should schedule an appointment if the issue is too complex or sensitive to discuss via email.
c) **All email will usually be printed and filed in the patient's medical record.**
d) Office staff may receive and read your messages.
e) Provider will not forward patient identifiable emails outside of USC healthcare providers without the patient's prior written consent, except as authorized or required by law.
f) The patient should not use email for communication regarding sensitive medical information.
g) Provider is not liable for breaches of confidentiality caused by the patient or any third party.
h) It is the patient's responsibility to follow up and/or schedule an appointment if warranted.

3. INSTRUCTIONS

To communicate by email, the patient shall:

a) Avoid use of his/her employer's computer.
b) Put the patient's name in the body of the email.
c) Key in the topic (e.g., medical question, billing question) in the subject line.
d) Inform Provider of changes in his/her email address.
e) Acknowledge any email received from the Provider.
f) Take precautions to preserve the confidentiality of email.

4. PATIENT ACKNOWLEDGMENT AND AGREEMENT

I acknowledge that I have read and fully understand this consent form. I understand the risks associated with the communication of email between the Providers and me, and consent to the conditions and instructions outlined, as well as any other instructions that the Provider may impose to communicate with patient by email. If I have any questions I may inquire with my treating physician or the USC Privacy Officer.

Patient signature_____
Date_____
Witness signature_____
Date_____

KAISER PERMANENTE®

Kaiser Foundation Hospitals
Permanente Medical Groups

# AUTHORIZATION FOR USE OR DISCLOSURE OF PATIENT HEALTH INFORMATION

Note: Fees may apply to certain requests

Patient Name: _____
Kaiser # _____ Date of Birth: _____
Address: _____
City: _____
State: _____ Zip Code: _____
Phone #: ( ) _____
Email: _____

**Kaiser Permanente will not condition treatment, payment, enrollment or eligibility for benefits on providing, or refusing to provide this authorization.**

**This authorizes the following Kaiser Permanente Medical Center(s):** _____

to disclose information as specified below for the following purpose(s): _____

**Kaiser Permanente may disclose this information to:**

☐ Check if same as above (disclosure to patient)

**Recipient Name:** USC Fertility
Address: 1127 Wilshire Blvd. Suite 1400
City: Los Angeles
State: California Zip Code: 90017
Phone #: (213 ) 975-9990 Fax #: (213 ) 975-9997
Email: diana.pagdilao@med.usc.edu

**Copies of records or medical record information within the following dates:** _____ **to** _____

☑ Both Hospital and Medical Office Records ☐ Medical Office Records ☐ Hospital Records
☑ Records limited to a specific provider: _____ or department: REI
☐ X-Ray films ☐ X-Ray Digital Images ☑ Laboratory Results

**NOTE: Hospital and Medical Office records may include disclosure of information related to mental health, alcohol/drug, and HIV references contained within those records as part of this authorization.**

**The actual treatment records from mental health, or alcohol/drug departments, or results of HIV antibody tests are specifically protected, and will not be disclosed unless you sign below.**

Mental Health department records → Signature: _____
Alcohol / Drug dependency treatment records → Signature: _____
HIV antibody test results → Signature: _____

**Media Type:** ☑ Electronic ☐ Paper **Delivery Preference:** ☑ Email/Secure Portal ☐ Mail ☐ Pickup

**DURATION:** This authorization shall remain in effect for one year from the date of signature unless a different date is specified here _____(date).

**REVOCATION:** You or your representative can revoke this authorization upon written request. If you revoke, it will not affect information disclosed before the receipt of the written request.

**REDISCLOSURE:** Once this health information is disclosed, how the recipient further discloses it may no longer be protected under federal privacy law (HIPAA). California recipients are required to obtain your authorization before further disclosing this information.

If you are requesting a form to be completed, we may substitute a standardized version of the form that provides the same or similar information requested.

A copy of this authorization is as valid as an original. I have the right to receive a copy of this authorization.

_____ _____ _____
Date Signature If not patient, print your name and relationship

SCAL: NS-9934 (6-12) SPANISH-NS-1614; CHINESE-NS-6274
NCAL: 90258 (REV. 6-12) SPANISH 01782-000; CHINESE 01782-002

ORIGINAL - DISCLOSING PARTY CANARY - PATIENT

USC Fertility
Alternatives for Today & Tomorrow

1127 Wilshire Boulevard, Suite 1400
Los Angeles, CA 90017

Tel: 213-975-9990
Fax: 213-975-9997

USCFertility.org

# PERMIT FOR RELEASE OF MEDICAL INFORMATION

TO: _____

_____

_____

I give my permission for you to release all of my medical records to:

**USC FERTILITY**
Richard J. Paulson, MD
Kristin Bendikson, MD
Karine Chung, MD
Marsha Baker, MD
Aline Ketefian, MD
Amy Dhesi, MD
1127 Wilshire Boulevard, Suite 1400
Los Angeles, CA 90017
Tel: 213-975-9990 Fax: 213-975-9997

Patient's Name: _____

Date of Birth: _____

Dates of Treatment: _____

Signature: _____

Date: _____

Witness: _____

USC Fertility
Alternatives for Today & Tomorrow

1127 Wilshire Boulevard, Suite 1400
Los Angeles, CA 90017

Tel: 213-975-9990
Fax: 213-975-9997

USCFertility.org

# INSURANCE DISCLAIMER

Please be advised that our practice does not contract with insurance companies for the treatment of infertility, obstetrics and gynecology, or other medical conditions. As a University of Southern California (USC) practice, our Tax ID is that of USC OB/GYN Associates. The contracting office at USC has negotiated with insurance companies under this Tax ID number. However services rendered through our office are excluded. We do not bill insurance companies for Assisted Reproductive Techniques (infertility) or OB/GYN services, but will provide patients with itemized statements for possible reimbursement. Payment for all treatment is due on or before the day the treatment is being rendered.

If you have any questions regarding the costs of your procedures or treatment, please speak with Gayane Kouyoumdjian or Hazel Olague, Financial Counselor.

Your signature below is required for our records to signify that you have read the above statement and understand our policies regarding payment for infertility and OB/GYN procedures and treatment.

_____ _____

Signature of patient or patient's representative Date

_____ _____

Signature of patient partner (if applicable) Date

- ☐ Not Present
- ☐ Declined

*USC Care Medical Group, Inc.*
*Keck Hospital of USC*
*USC/Norris Comprehensive Cancer Center & Hospital*

# Keck Medical Center of USC

## Patient Advance Notice of Charges for Medical Services

_____("USC Provider") is accepting the patient named herein as a cash paying patient based upon the statement made by the patient below for the services described below.

**Patient Name** (print): _____ **DOB** _____
**Medical Services**:

_____
(Summary of Services including Date of Service)

I,_____("Patient") am presenting myself as a cash-paying patient. As such, I personally assume all financial responsibility and obligation to pay in full the billed charges of the services and materials provided to me by the USC Provider upon my receipt of them. If I have any type of insurance coverage, I understand that these above services are either (1) considered out of network benefits; (2) not covered benefits; or (3) covered benefits that my insurer has to date not authorized me to receive.

I understand that the USC Provider may not be a contracted provider with my health insurance company. I understand that the USC Provider has no control over the insurance company's determination of the normal usual and customary charge or how the insurance company determines allowable charges. In the event my insurance company pays some portion of the medical services, I agree to pay the difference in full *regardless* of the amount that my insurance company may determine to be the "usual and customary" charge.

If the USC Provider is a contracted provider with my insurance company, but the services have not been authorized, or are not covered benefits, I understand that the rates that the USC Provider charges the Patient will in many cases be higher than the discounted contract rate the USC Provider has agreed to accept from the insurance company when services are authorized and/or covered. I expressly agree to pay the USC Provider's higher, billed charges amount.

I understand that the USC Provider is agreeing to provide the agreed-upon medical services on the terms stated above. I waive all rights that I or my insurer may have to pay the USC Provider at contractually discounted rates, which might have been applicable had my insurer authorized the services before they were performed and/or had the services been a covered benefit. I acknowledge that, if my insurer authorizes these services after they have been performed and reimburses me at rates less than the USC Provider's full billed charges, the USC Provider will have no obligation to reduce its charges or to return any part of my payment to me.

☐ I do not want my health information to be sent to my health plan.

_____ _____
**Patient Signature** **Date**

_____ _____
**USC Provider Representative** **Date**

*Note: This form should <u>not</u> be used for any patient whose health care is covered by a governmental agency.*

The Doctors of USC
Financial Responsibility

The Doctors of USC (USC Care Medical Group, Inc.) are committed to providing you with the best possible medical care and assistance with the payment cycle. In order to achieve these goals, we need your help and your understanding of our insurance and financial policy.

**Release of information:** I understand that to the extent necessary USC Care Medical Group, Inc. may release and disclose all or portions of my medical information for payment purposes in accordance with federal and state law. This means that USC Care Medical Group, Inc. may make such disclosures to any person or entity which is or may be responsible for all or part of the charges for services rendered to me (including, but not limited to, insurers, health care plans, welfare funds and workers compensation carriers) for the purposes of obtaining payment. I understand that I may need to sign a special authorization to release HIV test results, treatment information regarding drug or alcohol abuse and certain mental health records.

**Ancillary Services:** I understand if services are furnished by another USC provider (such as USC Radiology, USC Anesthesia, USC Pathology, USC Clinical Reference Laboratory, and other medical providers) these services will be included and billed on a single-billing statement with a complete itemization of each service.

**Assignment of Benefits:** I hereby assign my benefits to USC Care Medical Group, Inc. and authorize payment directly to it for any and all health insurance or health plan benefits otherwise payable on my behalf or to me for services it rendered.

**HMO Authorizations:** If your insurance is a HMO plan, you will be responsible to obtain authorization for treatment prior to your visit. Each visit or treatment requires authorization by your primary care physician.

**Financial Agreement:** I hereby agree that I am financially responsible for services rendered to me in accordance with the regular rates and terms with USC Care Medical Group, Inc. I accept full financial responsibility for all charges billed and guarantee to pay all such charges. I understand that USC Care Medical Group Inc. contracts with various health care plans, Medical Groups and Independent Physician Associations. I understand and agree that any charges not paid by my health plan or insurance benefits or otherwise not covered by my health insurance (including, but not limited to, co-payments, co-insurance, and deductibles) are my financial responsibility. All accounts are due and payable upon presentation of a statement. Co-payments are due at the time of your appointment prior to seeing your physician. Please note: USC Care Medical Group, Inc. is an out-of-network provider for some insurance companies, and you will incur a higher out of pocket expense when utilizing our services.

I have read and understand the above information. I understand that I am financially responsible for all charges whether or not paid by my insurance. I authorize the release of any medical information to my insurer or its agents in order to facilitate the payment of my medical benefits.

| | |
|---|---|
| _____ | _____ |
| Patient Name | Name of Representative |
| _____ | _____ |
| Signature of Patient/Patient Representative | Relationship to Patient |
| _____ | _____ |
| Date | Date |

*USC Care Medical Group, Inc.*
*USC University Hospital*
*USC/Norris Comprehensive Cancer Center & Hospital*

# USC Health Sciences Campus
# Point of Service Option (POS)/Out of Network

**Patient Name** (print) :_____**MRN:**_____

**DOB**_____ **SS#**_____**Date of Service:**_____

**Description of Services:** _____
_____

I, _____, am electing to receive care from a USC provider who is not part of my insurer's physician network. I understand that when receiving care out-of-network for services covered by my benefit plan, my insurer may impose a deductible and higher copayments than if I received services from a network provider. I understand that the services described above have not been pre-approved by my insurer as medically necessary or otherwise as a covered service by my benefit plan and, therefore, I might not be entitled to any reimbursement at all from my insurer.

**Bills will be submitted to my insurer at:**

Insurance Plan Name: _____
Address: _____
City, State, Zip: _____

**I agree to be personally responsible for all deductibles and copayments required under my benefit plan and, if payment for the services is denied in whole or in part by my insurer, I agree to pay upon demand the USC provider's unpaid charges.**

_____ _____
**Patient Signature** **Date**

_____ _____
**USC Provider Representative** **Date**

*Note: This form <u>should not</u> be used for any patients whose health care is covered by a Governmental agency.* *902*

## *PAYMENT REQUIREMENTS FOR ASSISTED REPRODUCTIVE CYCLES*

All charges related to an assisted reproductive cycle must be paid in full before procedures. **USC Fertility requires 100% pre-payment of all charges at the time of the initiation of the care (baseline scan). Cost of medication is not included.** Patients can obtain all medications from any pharmacy they wish. Please inquire with the nursing staff regarding recommended pharmacies specializing in fertility medications.

We are out of network with most payers and do not bill insurance. We currently only accept Harrington and Meritain supplemental insurance at this clinic. Patients with Harrington or Meritain coverage will pay 20% co insurance prior to services being provided. Co-insurance will be determined and capped based on package pricing. We can provide an itemized statement for the patient to submit to their insurance company for reimbursement should they have assisted reproduction coverage. **Patients are responsible for payment for all services.**

**An itemized statement of account can be generated four to six weeks after the end of each cycle. This paperwork is not generated automatically and therefore, a request must be placed with one of our financial counselors.**

Refunds of overpayment will be made when a particular treatment cycle is completed or interrupted for any reason.

USC Lab charges are approximately $92 to $107 fee for each hormone determination blood test requested. We do offer cash package pricing for all testing at the time of service. If the package pricing is paid, it will cover the cost of serum hormone determination blood testing during the stimulation as well as baseline estradiol and FSH and up to two (2) serum pregnancy tests following the embryo transfer. Additional tests or outside labs are not included in packages. You will be billed separately or directly by the outside provider.

_____ **Pt initials**

***ITEMS NOT INCLUDED IN CYCLE PRICING:***

**Other charges/tests not included in the package pricing are first time consult charge, Cystic Fibrosis, Tay-Sachs, Thallassemia, Sickle-Cell disease panels, Karyotype/Chromosome analysis, CMV, infectious blood disease screening, other required checklist screening items, biopsy cycle, hydrosonography, HSG, pre-op labs, all medications dispensed from our office, PGD coordination fee, PGD physician fee, semen analysis, ICSI, sperm cryopreservation, assisted embryo hatching, TESE, MESA, TET, annual storage fee for sperm, oocytes, or embryos, additional blood draws and testing beyond the package pricing, any other necessary care beyond the charges outlined on the cost sheet, and any Fed Ex shipments sent out to you.**

_____ **Pt initials**

**With a positive pregnancy outcome, you will be monitored by our doctors until your 6th to 8th week of pregnancy. There is a charge for the obstetrical ultrasounds along with any additional venipuncture fees and labs. <u>These additional services are not included in the package pricing.</u> Please ask the financial for pricing and any other questions regarding billing.**

_____**Pt initials**

In the event of cycle discontinuation, **the fees that will be charged are based upon those incurred as a result of treatment up to that point.** Cycle discontinuation is a relatively uncommon event that, in the majority of instances, is the result of a mutual agreement between the patient and the center. However, the center reserves the right to discontinue the treatment cycle for medical or other reasons. For donor and surrogate cycles, if the donor becomes incapacitated or cannot continue the cycle for personal or other reasons, the recipient couple remains financially responsible for any services rendered up to that point, including additional blood tests and other services.

**Please be sure to ask as many questions as necessary before signing this form.** Please be advised that the charges are incurred as a result of a professional service, not as a result of a particular outcome. No guarantee can be made as to whether or not your cycle will be successful.

**ALL SERVICES MUST BE PAID IN ADVANCE OR THE PROCEDURE WILL BE CANCELLED.**

**Please note: The storage fee for sperm, embryos, oocytes included in the package is for the first year of storage only. You will receive a yearly billing statement from our office for the annual storage fees, which are subject to reasonable annual increases to ensure they are in line with market rates. It is your responsibility to notify this office promptly if there are any changes with your contact information or if you would like to choose another option other than continued storage here at USC Fertility.**

**Your signature on this form indicates (1) that you have read and understood the entire preceding agreement and agree to all terms contained herein, (2) that you have had an opportunity to ask questions and have your questions answered, (3) that you have received all the information you desire concerning your assisted reproductive cycle and the payment requirements, and (4) that you have read the list of accompanying charges and that you agree to be responsible for all charges incurred during your care."**

| | |
|---|---|
| Patient Name | MRN |
| Signature of Acknowledgement | Date |
| Signature of Witness | Date |

# UNIVERSITY OF SOUTHERN CALIFORNIA
# NOTICE OF PRIVACY PRACTICES

## THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.
## PLEASE REVIEW IT CAREFULLY.

### What is this Notice and Why Is It Important?

By law, the University of Southern California (USC)[1] must protect the privacy of your identifiable medical and other health information ("health information").

USC also is required by law to give you this notice to tell you how we may use and give out ("disclose") your health information. USC must follow the terms of this notice when using or disclosing your health information.

This notice is effective as of January 1, 2016.

### How USC May Use Your Health Information

As a general rule, you must give written permission before USC can use or release your health information. There are certain situations where USC is not required to obtain your permission. This section explains those situations where USC may use or disclose your health information without your permission.

Except with respect to Highly Confidential Information (described below), USC is permitted to use your health information for the following purposes:

- **Treatment:** We use and disclose your health information to provide you with medical treatment or services. This includes uses and disclosures to:
  - treat your illness or injury, including disclosures to other doctors, practitioners, nurses, technicians or medical personnel involved in your treatment, or
  - contact you to provide appointment reminders, or
  - give you information about treatment options or other health related benefits and services that may interest you.

[1] For purposes of the HIPAA Privacy Rule, USC includes those entities that comprise Keck Medicine of USC, including but not limited to, USC Norris Cancer Hospital, Keck Hospital of USC, USC's employed physicians, nurses and other clinical personnel, those units of USC that provide clinical services within the Keck School of Medicine, School of Pharmacy, the Herman Ostrow School of Dentistry, Physical and Occupational Therapy as well as USC Care Medical Group, affiliated medical foundations of Keck and their physicians, nurses and clinical personnel, USC Verdugo Hills Hospital, its nurses and other clinical personnel, Verdugo Radiology Medical Group, Verdugo Hills Anesthesia, and Chandnish K. Ahluwalia, M.D., Inc. and those units that support clinical and clinical research functions, including the Offices of the General Counsel, Audit and Compliance.

- **Payment:** We may use and disclose your health information to obtain payment for health care services that we or others provide to you. This includes uses and disclosures to:
    - submit health information and receive payment from your health insurer, HMO, or other company that pays the cost of some or all of your health care (payor), or
    - verify that your payor will pay for your health care.

  However, we will comply with your request not to disclose health information to your health plan if the information relates solely to a healthcare item or service for which we have been paid out of pocket in full.
- **Health Care Operations:** We may use and disclose your health information for our health care operations, such as internal administration and planning that improve the quality and cost effectiveness of the care we provide you. This also include uses and disclosures to:
    - evaluate the quality and competence of our health care providers, nurses and other health care workers,
    - to other health care providers to help them conduct their own quality reviews, compliance activities or other health care operations,
    - train students, residents and fellows, or
    - identify health-related services and products that may be beneficial to your health and then contact you about the services and products.

We may also disclose your health information to third parties to assist us in these activities (but only if they agree in writing to maintain the confidentiality of your health information).

In addition, USC may use and disclose your health information under the following circumstances:

- **Organized Health Care Arrangement.** USC participates in organized health care arrangements (OHCA) with other providers, including but not limited to, Childrens Hospital Los Angeles and Los Angeles County+USC Medical Center (LAC+USC). USC may share information with its OHCA members for treatment, payment and joint health care operations.

- **Directory:** USC may include your name, location in its hospitals, general health condition and religious affiliation in a patient directory without obtaining your

authorization unless you object to inclusion in the directory. Information in the directory may be disclosed to anyone who asks for you by name or members of the clergy; provided, however, that your religious affiliation will only be disclosed to members of the clergy.

- **Relatives, Caregivers and Personal Representatives:** Under appropriate circumstances, including emergencies, we may disclose your health information to family members, caregivers or personal representatives who are with you or appear on your behalf (for example, to pick up a prescription). We may also need to notify such persons of your location in our facility and general condition. If you object to such disclosures, please notify your USC health care provider. If you are not present, or the opportunity to agree or object to a use or disclosure cannot practicably be provided because of your incapacity or an emergency circumstance, we may exercise professional judgment to determine whether a disclosure is in your best interests. If information is disclosed to a family member, other relative or a close personal friend, we would disclose only information believed to be directly relevant to the person's involvement with your health care or payment related to your health care.

- **Public Health Activities:** We may disclose your health information for the following public health activities:
  - To report to public health authorities for the purpose of preventing or controlling disease, injury or disability;
  - To report child abuse and neglect to public health authorities or other government authorities authorized by law to receive such reports;
  - To report information to the U.S. Food and Drug Administration (FDA) about products and services under its jurisdiction;
  - To alert a person who may have been exposed to a communicable disease or may otherwise be at risk of contracting or spreading a disease; or
  - To report information to your employer as required under laws addressing work-related illnesses and injuries or workplace medical surveillance.

- **Victims of Abuse, Neglect or Domestic Violence:** If we reasonably believe that you are a victim of abuse, neglect or domestic violence, we may disclose your health information as required by law to a social services or other governmental agency authorized by law to receive such reports.

- **Health Oversight Activities:** We may disclose your health information to a health oversight agency that is charged with responsibility for ensuring compliance with the rules of government health programs such as Medicare or Medicaid.

- **Specialized Government Functions:** We may use and disclose your health information to units of the government with special functions, such as the U.S. military, under certain circumstances required by law.

- **Law Enforcement Officials, Judicial and Administrative Proceedings:** We may disclose health information to police or other law enforcement officials. We also may disclose health information in judicial or administrative proceedings, such as in response to a subpoena.

- **Coroners or Medical Examiners:** We may disclose health information to a coroner or a medical examiner as required by law.

- **Organ and Tissue Donation:** We may disclose health information to organizations that assist with organ, eye or tissue donation, banking or transplant.

- **Health or Safety:** We may disclose health information to prevent a serious threat to your health and safety or the health and safety of the public or another person.

- **Research:** We may disclose health information without your authorization for certain research purposes. For example, we may disclose your information to researchers preparing a research protocol or if our Institutional Review Board committee (which is charged with ensuring the protection of human subjects in research) determines that an authorization is not necessary if certain criteria are met. We also may provide health information about you (not including your name, address, or other direct identifiers) for research, public health or health care operations, but only if the recipient of such information signs an agreement to protect the information and not use it to identify you.

- **Development Activities:** We may contact you to request a contribution to support important USC activities. For fundraising, we may disclose to our fundraising staff demographic information about you (for example, your name, address and phone

number), dates on which we provided health care to you, information about the department of service or treating physician, outcome information or health insurance status without your written permission. We also may share such information about you with closely related foundations that assist us in our development activities. We will provide you an opportunity to opt-out of receiving fundraising communications. We will not disclose your diagnosis or treatment, however, unless we have your written authorization to do so.

- **Marketing Activities:** We may conduct the following activities without obtaining your authorization:
  - Provide you with marketing materials in a face-to-face encounter;
  - Give you a promotional gift of nominal value;
  - Provide refill reminders or otherwise communicate about a drug or biologic that is currently prescribed to you, so long as any payments we receive for making the communication are reasonably related to our costs;
  - Tell you about USC's own health care products and services

If we accept payments from other organizations or individuals in exchange for telling you about their health care products or services, we will ask for your authorization, except as described above or unless the communications are permitted by law without your permission. We will ask your permission to use your health information for any other marketing activities. Also, from time to time, USC receives letters from patients, their family members and friends describing the experience and care they received at USC. Where possible, we share these letters with our USC employees and patients. Prior to sharing your letter, we will remove your name and other identifying information from the letter to protect your privacy.

- **Workers' Compensation:** We may disclose health information as authorized by and to the extent necessary to comply with laws relating to workers' compensation or other similar programs or as required under laws relating to workplace injury and illness.

- **As Required by Law:** We may disclose health information when required to do so by any other law not already referred to in the preceding categories.

## Your Written Authorization

FOR ANY PURPOSE OTHER THAN THE ONES DESCRIBED ABOVE WE MAY ONLY USE OR DISCLOSE YOUR PROTECTED HEALTH INFORMATION WHEN YOU GIVE US YOUR WRITTEN AUTHORIZATION.

## Highly Confidential Information

Federal and state law require special privacy protections for certain highly confidential information about you ("Highly Confidential Information"), including your health information that is maintained in psychotherapy notes or is about: (1) mental health and developmental disabilities services; (2) alcohol and drug abuse prevention, treatment and referral; (3) HIV/AIDS testing, diagnosis or treatment; (4) communicable disease(s); (5) genetic testing; (6) child abuse and neglect; (7) domestic or elder abuse; or (8) sexual assault. In order for your Highly Confidential Information to be disclosed for a purpose other than those permitted by law, your written authorization is required.

## Sale of Health Information

We will not make any disclosure that is considered a sale of your protected health information without your written authorization unless the disclosure is for a purpose permitted by law.

## Your Rights Regarding Your Health Information

**Right to Request Access to Your Health Information:** You have the right to inspect and maintain a copy of the patient records we maintain to make decisions about your treatment and care, including billing records. All requests for access must be made in writing. Under limited circumstances, we may deny you access to your records. If you would like access to your records, please ask your healthcare provider for the appropriate form to complete. If you request copies, we will charge you a reasonable fee for copies. We also will charge you for our postage costs, if you request that we mail the copies to you. If you are a parent or legal guardian of a minor, certain portions of the minor's medical record may not be accessible to you under California law.

**Right to Request Amendments to Your Health Information:** You have the right to request that we amend your health information maintained in your medical record file or billing records. If you wish to amend your records, please obtain an amendment request form from your healthcare provider. All requests for amendments must be in writing. We

will comply with your request unless we believe that the information that would be amended is already accurate and complete or other special circumstances apply.

**Right to Revoke Your Authorization:** You may revoke (take back) any written authorization obtained by us for use and disclosure of your protected health information, except to the extent that we have taken action in reliance upon it. Your revocation must be in writing and sent to the USC Office of Compliance or to whomever is indicated on your authorization.

**Right to An Accounting of Disclosures of Your Health Information:** Upon written request, you may obtain a list (accounting) of certain disclosures of health information made by us The period of your request cannot exceed six years. If you request an accounting more than once during a twelve (12) month period, we will charge you a reasonable fee.

**Right to Request how Information is Provided to You:** You may request, and we will try to accommodate, any reasonable written request for you to receive health information by alternative means of communication or at a different address or location.

**Right to Request Restrictions on the use of your Health Information:** You may request that we restrict the use or disclosure of your protected health information. All requests for such restrictions must be made in writing. While we will consider a request for additional restrictions carefully, we are not required to agree to a requested restriction, except for requests to restrict disclosure of information to a health plan in cases where you have paid for the service out of pocket and in full.

**Right to be Notified of Breach:** You have the right to be notified by us if we discover a breach of your unsecured protected health information.

**Right to a Paper Copy of this Notice:** Upon request, you may obtain a paper copy of this Notice, even if you have agreed to receive such information electronically.

**Right to Change Terms of this Notice**

We may change the terms of this notice at any time. If we change this notice, we may make the new notice terms effective for all health information that we hold, including any information created or received prior to issuing the new notice. If we change this

notice, we will post the revised notice in our practice areas and on our website at www.usc.edu/policies. You may also obtain any revised notice by contacting the USC Office of Compliance.

**Further Information; Complaints**

If you would like additional information about your privacy rights, are concerned that we have violated your privacy rights or disagree with a decision that we made about access to health information, you may contact our USC Office of Compliance. You may also file written complaints with the Director, Office for Civil Rights of the U.S. Department of Health and Human Services. Upon request, the USC Office of Compliance will provide you with the current address for the Director. We will not retaliate against you if you file a complaint with us or the Director.

**USC Office of Compliance**

You may contact the USC Office of Compliance at: 3500 Figueroa, #105, Los Angeles, CA 90089-8007, (213) 740-8258 or complian@usc.edu.

## UNIVERSITY OF SOUTHERN CALIFORNIA
## NOTICE OF PRIVACY PRACTICES

**Please sign and date below to indicate that you have received a copy of this notice. Your signature simply acknowledges that you received a copy of this notice.**

_____

Print Name (Last, First, Middle Initial)

_____

Signature

_____

Date

USC Fertility
Alternatives for
today & tomorrow

1127 Wilshire Boulevard, Suite 1400
Los Angeles, CA 90017

Tel: 213-975-9990
Fax: 213-975-9997

USCFertility.org

# CONSULTATION CONSENTS FORM

I, _____, understand that before any fertility treatment is initiated at USC Fertility that the following items must be completed:

1. Consent forms for treatment
2. Prenatal FAQ form
3. Genetic Screening Questionnaire
4. Embryo/Egg Storage Agreement (if applicable)
5. Blood draws for indicated lab tests [patient and partner (if applicable)]
6. Recommended evaluative procedures
7. Completed cycle checklist
8. Mutual Arbitration Form

| _____ | _____ | _____ |
|---|---|---|
| Patient Name | Signature | Date |
| _____ | _____ | _____ |
| Partner Name (if applicable)<br>☐ Not Present<br>☐ Declined | Signature | Date |