



Oocyte Donor : \_\_\_\_\_  
Oocyte Donor Partner \_\_\_\_\_

**AUTHORIZATION FOR COMMUNICATION OF PROTECTED HEALTH INFORMATION  
ANONYMOUS OR KNOWN OOCYTE DONOR**

The Health Information and Portability Protection Act of 1996 (the Privacy Rule) grants Federal protection from the unnecessary disclosure of your personal health information. The Privacy Rule requires healthcare entities to maintain the confidentiality and protection of your personal medical information. However, it may be necessary for members of your healthcare team to communicate your lab results, instructions, treatment information and other items of protected health information among the participants of an oocyte donor assisted reproduction cycle (herein referred to as assisted reproduction cycle) including intended parents, gestational carrier, and agencies that recruit egg donors and/or gestational carriers.

In order to remain in compliance with the Privacy Rule and for your participation as the assisted reproduction cycle, your expressed, written consent is required to disclose your personal health information among participants in the assisted reproduction cycle only to the extent necessary to facilitate and coordinate treatment during an IVF oocyte donation cycle.. Participants in the assisted reproduction cycle to whom disclosure may be made include intended parents, gestational carrier and agencies that recruit oocyte donors and/or gestational carriers.

In the event you are an anonymous oocyte donor, all personally identifiable information, i.e., name, date of birth, etc., will be withheld and disclosure will be limited to medical information needed to coordinate the assisted reproduction cycle.

This Authorization is voluntary. You may revoke this Authorization in writing at any time, except to the extent that action has already been taken. However, revocation of the Authorization may make you ineligible to continue participation in the assisted reproduction cycle.

This authorization is valid only during the current assisted reproduction and will automatically expire on \_\_\_\_\_.

**Attestation**

By signing this Authorization permitting the release of my personal health information, I agree to release, discharge and hold harmless all parties who receive and/or release such information from any liability that may arise.

I understand that releasing personal health information to an organization that may not be a health plan or a health care provider may make this information no longer protected by federal privacy laws in the event the information is re-disclosed by them.

I have been provided with a copy of Fertility Centers of Illinois' Joint Notice of Privacy Practices. I have had the opportunity to discuss this document and authorization with my physician and healthcare team and have had all my questions answered to my satisfaction.

I have read this document in its entirety and have ample time to reach my decision, free from pressure and coercion, and agree to the disclosure of personal health information among the participants of the current assisted reproduction cycle.

\_\_\_\_\_  
Oocyte Donor

\_\_\_\_\_  
Date

\_\_\_\_\_  
Oocyte Donor Partner

\_\_\_\_\_  
Date

\_\_\_\_\_  
Witness

\_\_\_\_\_  
Date



Oocyte Donor : \_\_\_\_\_  
Oocyte Donor Partner \_\_\_\_\_

**Picture Identification**

(F) Type: \_\_\_\_\_ (M) Type: \_\_\_\_\_

Picture Identification Confirmed on Date: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Signatures of consenting parties must be notarized if the consent is signed outside the presence of a Center employee.**

**Notary Attestation**

**Oocyte Donor**

State of \_\_\_\_\_

County of \_\_\_\_\_

I certify that I know or have satisfactory evidence that \_\_\_\_\_ is the person who appeared before me, and said person acknowledged that he/she signed this instrument and acknowledged it to be him/her free and voluntary act for the uses and purposes mentioned in the instrument.

Dated \_\_\_\_\_

\_\_\_\_\_

My appointment expires \_\_\_\_\_

**Oocyte Donor Partner**

State of \_\_\_\_\_

County of \_\_\_\_\_

I certify that I know or have satisfactory evidence that \_\_\_\_\_ is the person who appeared before me, and said person acknowledged that he/she signed this instrument and acknowledged it to be him/her free and voluntary act for the uses and purposes mentioned in the instrument.

Dated \_\_\_\_\_

\_\_\_\_\_

My appointment expires \_\_\_\_\_