VASECTOMY AND MALE INFERTILITY CENTER OF CONNECTICUT
PERMISSIONS/RELEASE/ASSIGNMENT/NOTICES

CONSENT TO TREATMENT AND DIAGNOSTIC PROCEDURES: "This is to certify that I, the undersigned, consent to the administration of treatment at the Vasectomy and Male Infertility Center of Connecticut (VMIC) by its physicians and ancillary providers. I consent to any x-ray, laboratory, medical procedures of examination and other services rendered to me under the general and specific instruction of Dr. Matson. I understand that, except in emergency, all special procedures including vasectomy will be discussed with me and that an additional specific consent form will be required. Unless revoked in writing this permission will be in effect while I am under the care of the Vasectomy and Male Infertility Center of Connecticut."

_____ _____
Signature of Patient Date

AUTHORIZATIONS TO RELEASE MEDICAL INFORMATION: "I consent to allow the VMIC, as defined above, to disclose my protected health information within VMIC, to carry out my treatment, to obtain payment, and to carry out health care operations. My protected health information may be disclosed to my health plan and/or its agents as necessary to verify benefits, authorize services, and process medical claims. My protected health information may be disclosed to outside heath agencies or institutions involved in my continuing care when I am transferred to another facility and/or for emergency purposes. My physician may also share information with referring physicians for continuing care as deemed appropriate by me. My protected health information may include medical information or any pertaining to the examination, treatment, history, which may include psychiatric, HIV/AIDS, sickle cell, alcohol and/or drug information, coded medical information, and charges to my health plan and/or their acting intermediaries and/or agents. This consent is subject to revocation at any time except to the extent that action has been taken in reliance on it; withdrawal of consent shall be addressed in writing to Dr. Matson."

_____ _____
Signature of Patient Date

ASSIGNMENT OF BENEFITS: "I authorize my health plan to pay benefits directly to VMIC. I understand that in the event my health plan or healthcare contract does not cover services, I will be responsible for payment. Examples include co-payments, deductibles, co-insurance, or uncovered services. I understand that if my health plan does not consider VMIC, or any provider under contract with them, a participating provider, charges incurred will be paid by me. I further agree to accept full financial responsibility for payment of charges not covered by this assignment and agree to bear any reasonable cost of collection including court costs and attorney's fees, should this be required."

_____ _____
Signature of Patient Date

ACKNOWLEDGEMENT OF RECEIPT: NOTICE OF PRIVACY PRACTICES: "I understand that specific information regarding the uses and disclosures of my medical information can be found in the VMICC Notice of Privacy Practices which has been provided to me and which I have a right to review before I sign this. I further understand that the VMIC has a right to change its Notice of Privacy Practices and that I may obtain a revised copy at the practice web site www.VasectomyCT.com. I understand that I have the right to request in writing that VMIC restrict how my protected health information is used and disclosed for treatment, payment and health care operations. I further understand that VMIC is not required to agree to my requested restrictions. However, if VMIC agrees to a requested restriction, it is bound by it."

_____ _____
Signature of Patient Date

Patient has: ___ refused to sign; ___ been unable to sign though good faith efforts have been made.
Explanation:

_____

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