YALE UNIVERSITY HIPAA AUTHORIZATION

Patient Name: _____

Laboratory Director: **Harvey J. Kliman, MD, PhD**

BACKGROUND

Thank you for your interest in the Endometrial Function Test® (EFT®). In order to assess the usefulness of this test it may be necessary to obtain follow up information from the medical records of all patients who undergo the Endometrial Function Test® (EFT®).

It is our hope that with this information we will continue to improve the utility of the Endometrial Function Test® (EFT®) as a diagnostic tool and make it available to all women undergoing assisted reproductive technology.

This form of consent will allow the physicians and their staff who perform the Endometrial Function Test® (EFT®) to obtain basic clinical information about your current health, reproductive history, as well as follow up information, if necessary. By signing this consent you are authorizing the retrieval of only infertility related medical information. This information will be obtained from your infertility related medical records and will be sent by your physician's staff to us and stored in a secure clinical research database exclusively controlled by Harvey J. Kliman, MD, PhD and his staff. The medical information will be entered into the database by Dr. Kliman's staff only.

You have the right to refuse to sign this form. Your health care outside of the performance of the EFT, the payment of your health care, and your health care benefits will not be affected if you do not sign this form.

If you do not sign this form we will not be able to perform the EFT on your biopsy specimen.

If you sign this form, you may change your mind at any time, but we may still use the information collected before you changed your mind in order to evaluate the utility of the EFT. This form will never expire unless and until you change your mind and retract it. To retract the permission to use your information please write to Harvey J. Kliman, M.D., Ph.D.

The Protected Health Information (PHI) we collect from your infertility specialist will only be used along with the other records of patients who have had the Endometrial Function Test® (EFT®)), like yourself. No identifying information will be published or disclosed about you specifically. All reasonable efforts will be made to protect the confidentiality of your PHI, which may be shared with others to support the research, to conduct public health reporting, and to comply with the law, as required. Despite these protections, there is a possibility that information about you could be inadvertently used or disclosed in a way that it will no longer be protected.

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WHAT IS COVERED BY THIS AUTHORIZATION

Who will disclose, receive, and/or use the information?

The following people may only use and disclose your infertility related follow up information to the other members on this list, to you, or as required by law.

The following health care providers are:

1. Harvey J. Kliman, MD., Ph.D.,
2. Dr. Harvey Kliman's clinical staff,
3. your infertility specialist and their staff,
4. health care providers who provide services to you in connection with this evaluation.

What personal health information will be used or disclosed?

No information will be disclosed or released to any other parties.

SIGNATURE

I have read this form and all of my questions about this form have been answered. By signing below, I authorize the described uses and disclosures of information.

_____

Signature of Patient **Date**

_____

Please Print Name

CONTACT INFORMATION

The contact information of the patient or personal representative who signed this form should be filled in below.

Address: _____
_____
_____

Telephone: _____

Email: (optional) _____

THE PATIENT OR HIS OR HER PERSONAL REPRESENTATIVE MUST BE PROVIDED WITH A COPY OF THIS FORM AFTER IT HAS BEEN SIGNED.