Patient and Partner Disclosure and Communication Consent

Female Patient Name: _____ DOB: _____

Male Patient Name: _____ DOB: _____

Semen Analysis and Sperm Wash Record Disclosure Consent

By signing this document, I consent to have Infinite Health Collaborative (i-Health) include a copy of my lab result(s) stored in my partner's medical record. I also consent to have my lab result(s) disclosed as a part of my partner's designated record set. This may include, but is not limited to, disclosures to my partner, to other healthcare providers, for payment purposes, and healthcare operations.

Communication Consent

I authorize i-Health to communicate my lab results to myself and my partner listed below:

Male Patient Phone Number: _____

Female Patient Phone Number: _____

If you are unable to answer the call, we would like to leave a message on your voicemail with your test results. We will not do so without your authorization.

☐ Yes, I authorize i-Health to leave a confidential message with my test results at the phone number I have provided and/or the phone number indicated above. I understand I can call back with questions at any time.

☐ No, I do not authorize i-Health to leave a confidential message with my test results on my voicemail. I understand that if I do not answer my phone, I will need to call my clinic to receive my test results.

By my signature below, I hereby acknowledge that I have read and understand the information provided on this Consent Form. I consent to the disclosure and communication methods outlined in this Consent Form. I understand that i-Health cannot order, nor be responsible, for my partner's tests without this release.

_____ _____

Female Patient Signature Date

_____ _____

Male Patient Signature Date