



Patient HIPPA Consent Form

24 Chromosome Aneuploidy Screening with aCGH

Authorization to Use Your Health Information

The Health Insurance Portability and Accountability Act (HIPAA) of 1996, requires your authorization to allow your health information to be shared between members of medical and testing teams working with you during the IVF process. There may be times where members of the BlastoGen team (our staff and laboratory personnel running the preimplantation genetic screening (PGS) test, our genetic counselor with whom you will have the opportunity to speak, etc.) may need to share information with your IVF physician and/or other members of the IVF facility or other medical organizations participating in your care. This document, the "Patient Authorization", describes your rights and discusses how information may be shared.

Please read this form carefully. When you have finished reading it, please sign and date the form and return it to BlastoGen along with your Patient Consent form so that we may begin the testing process. Your information will only be used in accordance with this authorization form, the informed consent form, and as required or allowed by law.

How will my health information be used?

BlastoGen, as your PGS test providers, are only a part of your IVF team. There may be occasions when we need to share information with your other care providers or when they may have to share information with us. Your health information will always be handled in a secure way, and only when needed to provide you with the best care possible.

What Personal Health Information May be Shared?

Personal information may include, but is not limited to:

- Name and contact information (e.g., phone #, email address)
- Dates (e.g., Date of Birth, egg retrieval date, etc.)
- Clinical outcome information
- Identifying numbers (e.g., insurance, medical record #s)
- Genetic information (mutations, markers, polymorphisms, and family history)

Who May Use or Disclose the Information?

The following parties are authorized to use and/or disclose your health information in connection with your use of BlastoGen's commercial testing service:

- Any of the laboratory staff at BlastoGen
- BlastoGen's genetic counselor



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- Your medical team (reproductive endocrinologist, nurse coordinator, embryologist, etc.)
- Outside medical staff (e.g., laboratory staff at external testing laboratories)
- United States Food and Drug Administration or other governmental surveillance organization

Do I have to sign this authorization form?

You do not have to sign this authorization form. If you do not sign, however, you will not be able to use our PGS testing services.

If I sign, can I revoke my authorization later?

If you provide us authorization to access your health information, you are free to withdraw your authorization regarding the use and disclosure of your health information at any time. After any revocation, your health information will no longer be used or disclosed. However, if you choose to revoke authorization in the midst of the testing process, you may still be responsible for any costs incurred up to the date of your revocation. If you wish to revoke your authorization for the disclosure of your health information, you must notify Blastogen in writing at the address below:

BlastoGen
406 Amapola Avenue
Suite 225. Torrance, CA 90501
Phone: 310-618-0618
Fax: 310-618 9438

I hereby authorize the staff to disclose my health information to Blastogen, and their staff for the purpose of conducting a Preimplantation Genetic Screening (PGS) procedure and resulting pregnancy and childbirth follow-up.

-Information to be disclosed will be limited to:

-Preimplantation genetic diagnosis related information

-Previous History of Infertility and Pregnancy

-Genetic History including Karyotype and other tests



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- IVF Stimulation information and progress
- Embryology Records after IVF Procedure
- Embryo Replacement and Pregnancy testing results
- Gestation and Childbirth Results
- Genetic Test Results (If applicable) of Product of Conception
- Child Information & Genetic Follow-up if Available

I have read this authorization form and agree to allow Blastogen to provide or exchange health information about me (us) as described above.

Signature of Female Patient

Signature of Partner/Spouse

Date

Date