Partner Testing Consent

Patient name (female):_____ Date of birth_____

Partner's name (male): _____ Date of birth_____

We, the above named individuals, request that Baystate Ob/Gyn Group, Inc. order the appropriate infertility-related testing for _____.
(Partner's Name)

We acknowledge that the test results will be given to Baystate Ob/Gyn Group, Inc. and will become part of the patient's medical record (ie, the male partner's results will appear in the female patient's medical record at Baystate Ob/Gyn Group, Inc.).

We also acknowledge that this information falls under HIPAA guidelines; for the purpose of treatment, payment, and healthcare operations, the results may be forwarded to other entities (including, but not limited to another treating healthcare provider).

Patient's signature (female)_____ Date_____

Partner's signature (male)_____ Date_____