玉兰生殖遗传医学研究所
Yulane Reproductive Genetics Institute
2825 N. Halsted Street, Chicago, IL 60657 Toll Free: 1-888-600-0188

AUTHORIZATION TO RELEASE THE MEDICAL INFORMATION

Full Name of Clinic/Hospital/Physican _____

Patient First Name _____ Patient Middle Name_____ Patient Last Name_____

Patient Other Name 1 _____ Patient Other Name 2 _____ Birth Date (dd-mm-yy) _____

I, _____, hereby authorize:

Robert Shearer, Esq.
Yulane Reproductive Genetics Institute
2825 North Halsted Street
Chicago, IL 60657
Email: msp@yulane.com
Fax: 866-515-6350
call 773-467-7147 to confirm

to disclose my Health information to authorized persons and/or entity for the needs of surrogacy, and permit such authorized persons and/or entity to view or make copies of the Health and Information

This authorization applies to all information contained in any report or any other information generated as a result of any counseling, psychological, medical or physical examinations or testing undergone or relating to any psychological, mental, medical or physical condition, illness, injury and any treatment or medication relating thereto, including review of any radiology results and reports relating thereto. This authorization also shall permit the authorized persons named above to discuss any of the foregoing with the treating medical provider or such medical provider's authorized personnel.

The purpose of this Authorization to Release Health Information is to provide the authorized persons/ entities named above with full disclosure of all health information that may be relevant to a surrogacy pregnancy and birth.

I understand:

- I may refuse to sign this authorization and my refusal will not affect my ability to obtain treatment.
- The recipient may not lawfully further use or disclose the health information unless another authorization is obtained from me or unless the disclosure is specifically permitted by law.
- This authorization shall become effective immediately.
- I reserve the right to withdraw or revoke this authorization, in writing, at any time.
- I understand that I have a right to receive a copy of this authorization.
- This release is revoked and will terminate at the end of all treatment received due to the terms of this Agreement.

Notes

this text box is editable. try it and fell it. click to edit or remove all texts replacing your own words..

Billing Information:
Yulane Payable
2825 North Halsted Street Chicago, IL 60657
Direct : 773-467-7147 (ask Chris at chrispilto@wecare.yulane.com)
Operator: 888-616-0188
Fax: 866-515-6350

Signature _____

PRINT NAME _____

Signature Date _____