ReproMed FERTILITY

CONSENT TO DISCLOSE PERSONAL HEALTH INFORMATION

I _____ (patient) _____ (partner)

herby authorize **Dr. Alfonso Del Valle of ReproMed Fertility Inc.**
56 Aberfoyle Cres. Suite 300, Toronto, ON, M8X 2W4, Fax (416) 233-8360

to obtain from the records of _____
(Name of patient) (Birth date)

_____
(Name of patient) (Birth date)

Mailing Address of Patient(s): _____

_____

The undersigned hereby authorizes and requests: (Name and address of Physician/Institute)

Physician/Institution: _____

Address: _____

Telephone: _____ Fax: _____

To disclose the following personal health information:

_____

_____
(Description of personal health information to be disclosed and dates of contact/hospitalization)

I understand that this personal health information is to be used **only** by the recipient for the purposes of: **FERTILITY ASSESSMENT/TREATMENT.** I hereby waive any and all claims against Dr. Alfonso Del Valle and ReproMed Fertility Inc. in connection with the disclosure of this personal information.

_____ _____
(Patient's Signature) (Partner's Signature)

Date: _____