Authorization for Release of Medical Information

Release Medical Information On_____
(Name of person whose information will be released)

Account #: _____ Birth Date: _____

Primary Phone: _____ Email: _____

RELEASE INFORMATION FROM:

Fairfax Cryobank/Cryogenic Laboratories, Inc.

RELEASE INFORMATION TO:

Name (include Clinic Name if applicable):_____

Address: _____

Address: _____

Phone: _____ Fax:_____ Email: _____

I hereby authorize Fairfax Cryobank and/or Cryogenic Laboratories Inc., to release to the name listed above any medical records and all other individually identifiable health information about me, whether or not contained in my medical records, regarding any past or present medical conditions, including but not limited to my client account number, specimen quality, order history and medical information. I understand that this authorization is voluntary and that if the individual or entity authorized to receive this information is not a covered entity under federal privacy regulations, the release of such information may no longer be protected by federal privacy regulations. I also understand that once this information is used or disclosed pursuant to this authorization it may be subject to re-disclosure by the name(s) above and may no longer be protected.

_____ _____
Signature of person whose information will be released Date