Authorization and Consent to Release Personal Health Information

By signing below, I consent to the release of information about me, including but not limited to my personal health information, by my health care provider (named below) and its employees to Giving Grace Foundation.

I authorize Giving Grace Foundation to contact any individuals or entities listed in this application for purposes of gathering information about me, including but not limited to my personal health information, to evaluate my application with Giving Grace Foundation.

Specifically, I permit my health care provider (named below) to release the following checked items:

☐ Information verifying that I have an infertility treatment plan

☐ Any health information regarding my infertility treatment specifically requested by Giving Grace Foundation

Health care provider entity (e.g., XXX Clinic):

Phone number:

Address:

Physician/Practitioner:

Printed Applicant's Name _____ Applicant's Signature _____ Date

Print Partner's Name _____ Partner's Signature _____ Date

All information submitted to Giving Grace Foundation and received from your clinic will be reviewed only by board members.