AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION VIA FERTILITY FRIENDS FOUNDATION (FFF) MEDICAL EVALUATION

PART A: Applicant Information

Full Name: _____
Date of Birth: _____
Address: _____
Phone: _____
Email: _____

Co-Applicant (if applicable): _____

PART B: Clinic / Physician Information

Physician Name: _____
Clinic Name: _____
Clinic Email: _____
Clinic Phone: _____

PART C: Purpose of This Authorization

I authorize my physician and/or fertility clinic to share relevant medical information via the electronic version of FFF medical evaluation with:

Fertility Friends Foundation
2225 Sheppard Avenue East, Atria III, Suite 903
North York, ON M2J 5C2
Email: info@fertilityfriendsfoundation.com

This information will be used **only** to support the review of my application for a Fertility Friends Foundation grant to assist with fertility treatment costs.

Information to Be Shared

I authorize the release of medical details related to my fertility journey, via the electronic version of FFF medical evaluation including:

- Diagnosis and fertility history relevant to treatment;
- Recommended treatment plan and procedures;
- Estimated treatment costs; and
- Any other details necessary for the evaluation of my grant application.

PART D: Privacy & Consent

- This authorization is voluntary and can be revoked at any time by emailing both my clinic and Fertility Friends Foundation.
- Information shared with Fertility Friends Foundation will be kept confidential and used only for the purposes of evaluating my grant application.
- Once my/our health information is disclosed to Fertility Friends Foundation, it may no longer be protected by health privacy legislation and could potentially be re-disclosed. However, FFF has represented that it will protect my/our information in accordance with applicable privacy laws and will use it only for the stated purpose.
- This authorization will expire **12 months from the date of signing** unless revoked earlier.

Signature

Applicant Signature: _____ Date: _____
Print Name: _____

Co-Applicant Signature (if applicable): _____ Date: _____

For the Clinic

Please return the completed medical evaluation securely via FFF electronic form:
www.fertilityfriendsfoundation.com/medical-evaluation
If you have questions, email **info@fertilityfriendsfoundation.com**