Brilora Fertility
FOUNDATION

Patient Authorization for Use and Disclosure of Protected Health Information

By signing, I authorize Gago Center For Fertility to disclose certain protected health information about me to the Brilora Fertility Foundation ("Brilora").

This authorization permits Gago Center For Fertility to disclose health information about me (and my spouse or partner, if applicable) for the purpose of applying for a grant from Brilora. Such information includes, but is not limited to, all my individually identifiable health information and medical records and all other information regarding my past, present, or possible future medical condition(s) or treatment(s) that are in any way related to my fertility (or my spouse or partner). This Authorization will expire two (2) years after the close of the selection process for the grant given by Brilora.

I understand that I may revoke this authorization at any time by notifying Brilora, in writing, by sending a letter to the attention of the President (lc@brilorafertility.com). However, the revocation will not be valid if Brilora has taken action in reliance on this Authorization. I understand that my enrollment or eligibility for the Brilora grant is not conditioned on whether I sign this Authorization. I understand the potential for information disclosed pursuant to this Authorization to be subject to disclosure by the recipient and no longer be protected.

On behalf of Gago Center For Fertility, I have completed the HIPAA form provided from them and acknowledge my responsibility in confirming this has been attained.

_____	_____	_____
Applicant: Print Name	Applicant: Signature	Date
_____	_____	_____
Partner (if applicable): Print Name	Partner (if applicable): signature	Date