REPROTECH
LIMITED

Complete this form ONLY if you wish to authorize disclosure of your records to another party, i.e. spouse, parent, etc. This form is not necessary to authorize release to your clinic.

Authorization of Release of Protected Health Information to Another Person

I (We) authorize ReproTech LLC to disclose my complete health record which may include, but is not limited to, personal biographical and medical information, specimen processing/cryopreservation, communicable diseases (including HIV and AIDS) to:

Enter the name of a person, other than yourself or clinic staff, whom you would like to have access to your account information:

_____

Relationship to me (us) _____

Address_____

City_____ State _____Zip _____

Phone: (____) ____ - _____ Email: _____

This authorization for release of information covers the period of healthcare from all past, present and future periods. I (We) understand that this authorization is voluntary. I (We) 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 by federal or state law. I (We) further understand that this authorization shall be in force and effective until I (we) revoke this authorization, in writing, at any time. I (We) understand that the revocation is not effective to the extent that any person or entity has already acted on our authorization.

Name:	_____ Client Depositor (Print)		_____ Co-Client Depositor (if applicable)	
Signature(s):	_____ Client Depositor Signature	_____ Date	_____ Co-Client Depositor Signature (if applicable)	_____ Date
Address:	_____		_____	
	_____		_____	
Phone:	(____) _____ - _____		(____) _____ - _____	
Date of Birth:	_____		_____	

RTL Account # _____(completed by RTL staff)

The Cryostorage & Compliance Experts

Florida 888-953-9669 • Minnesota 888-489-8944 • Nevada 888-831-2765 • Texas 888-350-3247