

CONSENT TO DISCLOSE PERSONAL HEALTH INFORMATION

I _____ (patient) _____ (partner)
hereby authorize **Dr. Alfonso P. Del Valle, M.D., FRCSC of 300-56 Aberfoyle
Crescent, Etobicoke, Ontario M8X 2W4 Phone (416) 233-8111 Fax (416) 233-8360**

from the records of _____
(Name of patient) (Birth date)

(Name of patient) (Birth date)

Mailing Address of Patient(s): _____

The undersigned hereby authorizes and requests: (Name and address of Physician/ Institute)

Physician/Institution: _____

Address: _____

Telephone: _____ Fax: _____

To disclose the following personal health information:

(Description of personal health information to be disclosed and dates of contact/hospitalization)

I understand that this personal health information is to be used **only** by the recipient for the purposes of: **FERTILITY ASSESSMENT/TREATMENT.**

I hereby waive any and all claims against **Dr. Alfonso P. Del Valle** in connection with the disclosure of this personal health information.

(Patient's Signature)

(Partner's Signature)

Date: _____