AUTHORIZATION FOR THE RELEASE OF MEDICAL INFORMATION:

NAME: _____ DATE OF BIRTH: _____

SS #: _____ PHONE #: _____

I request that my health care records from (Provider):

Facility Name: _____

Address: _____

Phone: _____ Fax: _____

Be Sent To (Recipient):

Facility Name: SURROGACY INTERNATIONAL, INC.

Address: P.O. BOX 552, LOS OLIVOS, CA 93441

Phone: (805) 697-7955 Fax: (805) 697-7410

I hereby voluntarily request and authorize the above health care provider(s) to use and/or disclose my health care information to the recipient that I have identified above. Please release the following treatment and healthcare information in furtherance of my proceeding with a gestational surrogate undertaking.

☑ Medical records for the last TWO (2) years including physician notes, progress notes, History & Physicals, treatment and medication records, diagnostic and laboratory records, pap smears, STD testing, etc.

☑ OBGYN records & labor/delivery records for any and all previous pregnancies.

☑ All Psychological Records

☑ Other: I give permission for the above medical provider and/or their office and staff to speak directly with the staff and attorneys of Surrogacy International, Inc..

I expressly understand that this consent may include treatment for physical and mental illness, alcohol/drug abuse, and/or HIV/AIDs and other STI test results or diagnosis. I understand that any personal health information or other information released to the person or organization identified above may be subject to re-disclosure by such person/organization and may no longer be protected by applicable federal and state privacy laws. This authorization is valid from the date of me signing this Agreement and for two years thereafter. I understand that I have a right to revoke this authorization by providing written notice to the above stated healthcare provider. However, this authorization may not be revoked if action has already been taken on this authorization prior to receiving my written notice. I also understand that I have a right to have a copy of this authorization. I further understand that this authorization is voluntary and that I may refuse to sign this authorization. My refusal to sign will not affect my eligibility for benefits or enrollment or payment for or coverage of services.

X _____ _____ _____

(Signature of Patient/Guardian) (Printed Name) (Date)