Patient Authorization for Use and Disclosure of Protected Health Information

By signing, I authorize Reproductive Medicine Associates of Michigan ("RMA of MI") to disclose certain protected health information about me to the Chosen Infertility Group ("Chosen").

This authorization permits RMA of MI to disclose health information about me (and my spouse or partner, if applicable) for the purpose of applying for a grant from Chosen. 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 Chosen.

I understand that I may revoke this authorization at any time by notifying Chosen, in writing, by sending a letter to the attention of the President (lc@choseninfertility.com). However, the revocation will not be valid if Chosen has taken action in reliance on this Authorization. I understand that my enrollment or eligibility for the Chosen 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 RMA of MI, I have completed the HIPAA form provided on the website (rmami.com) 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