MEDICAL AUTHORIZATION

TO: Heartland Fertility & Gynecology Clinic, Winnipeg, Manitoba

RE:____________________________________ (name of applicant and date of birth)

and ____________________________________(name of co-applicant and date of birth)

We, ____________________and ____________________ , the undersigned, hereby authorize you to release to Giving Hope Fertility Assistance Fund, of Winnipeg, Manitoba (hereinafter the "Fund"), any and all medical information pertaining to me, which may be contained in your records, including any and all x-rays, hospital records, medical reports, progress notes, reports of diagnostic tests, medical opinions and/or any other knowledge or information in your possession and for doing so, this, or a photocopy thereof, shall be your good and sufficient authority. I also authorize you to discuss any information with a representative of the Fund including (but not limited to) details of the medical care or treatment I have received or relating to any diagnosis or condition, including answering any questions the representative may have.

DATED at Winnipeg, Manitoba, this ________ day of ______________ , 20____ .

________________________________ ________________________________
(applicant signature) (co-applicant signature)

________________________________ ________________________________
(witness signature) (witness signature)