



SURROGATE PARENTING CENTER OF TEXAS
5646 Milton Street, Suite 316
Dallas, Texas 75206

AUTHORIZATION FOR RELEASE OF INFORMATION

**To: ANY PHYSICIAN, MEDICAL FACILITY, PSYCHIATRIST,
PSYCHOLOGIST, OR OTHER HEALTH CARE OR MENTAL HEALTH
PROFESSIONAL:**

YOU ARE HEREBY AUTHORIZED to release to the Surrogate Parenting Center of Texas any and all medical, psychological, psychiatric, or health information pertaining to me.

The Surrogate Parenting Center of Texas is expressly authorized to copy, or receive copies of, any records or documents pertaining to me and to distribute said copies to any other interested physician, psychiatrist, psychologist or health care or mental health professional who requires the information for purposes of medical or psychological assessment or treatment.

The information may be used in connection with the ovum donation agreement I have entered into with the Surrogate Parenting Center of Texas.

This authorization shall remain valid for two years from the date hereof.

I have been advised of my right to receive a copy of this Authorization.

Date: ____/____/____

Ovum Donor Signature: _____