

**AUTHORIZATION FORM FOR THE RELEASE OF PATIENT INFORMATION**

I hereby authorize the use and disclosure of the results of my tests for infectious diseases in connection with my donation of blood, collected from my baby's umbilical cord and placenta ("cord blood") at the time of my delivery for the collection, processing and storage of cord blood. I understand that this authorization is voluntary.

I understand that in order to proceed with the cord blood donation, I will be required to have certain infectious disease tests performed on both my blood and the cord blood.

I hereby authorize the use or disclosure of these test results to M.A.Z.E. Cord Blood Laboratories, Inc. ("M.A.Z.E."), the vendors with which M.A.Z.E. has arrangements for the provision of such infectious tests ("Vendors"), my obstetrician or certified nurse midwife, and such governmental or regulatory agencies as may be required by law.

I understand that this authorization will not expire. I further understand that I may revoke this consent, but that if I do so I will not be eligible to participate in the cord blood service provided by M.A.Z.E. I understand that to revoke this consent at any time I must mail a signed letter of revocation to M.A.Z.E. Cord Blood Laboratories, Inc. at 2975 Westchester Avenue, Purchase, New York 10577. I understand that revoking this consent will prohibit M.A.Z.E. from using and disclosing my identifiable test results after the date my letter of revocation is received and processed by M.A.Z.E.; however, it will not affect any prior use or disclosure of my identifiable test results. I understand that I will get a copy of this form after I sign it.

I also understand that if a person or organization authorized to receive my information is not a health plan or health care provider, the released information may be subject to re-disclosure and may no longer be protected by the federal privacy regulations.

\_\_\_\_\_  
Signature of patient or patient's representative

\_\_\_\_\_  
Date

**If this authorization is signed by a patient's representative, please complete the following:**

\_\_\_\_\_  
Printed name of patient's representative:

\_\_\_\_\_  
Relationship to the patient:

Describe the representative's authority to act for the patient :  
\_\_\_\_\_  
\_\_\_\_\_