ASSISTED
FERTILITY
PROGRAM

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REQUEST FOR RELEASE OF MEDICAL RECORDS

Patient's Name _____

Address _____

City/State/Zip _____

Phone _____ Fax _____

Send records by: ☐ Mail ☐ Fax ☐ Pick up in office

I understand these records contain information from other health care providers, as well as information which is administrative in nature. I specifically consent in the release of any information contained in the medical records which may relate to infection with Human Immunodeficiency Virus (HIV), AIDS or related conditions.

Patient Name: _____

Date of Birth _____ Social Security Number _____

Patient Signature _____ Date _____

Please send the following information:

_____ Send all my records

_____ Medical information, including physician notes/summaries and diagnostic results for the period from _____ to _____

_____ Other: Specify information to release _____

_____

Thank you for your assistance.