The Fertility Center

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3230 Eagle Park Dr. NE, Suite 100	1100 S. Cedar St., Suite 2	317 S. Drake Rd., Suite B
Grand Rapids MI 49525	Mason, MI 48854	Kalamazoo MI 49009
616.988.2229	877.904.4483	269.324.5100
877.904.4483		877.500.1658

REQUEST FOR RELEASE OF MEDICAL RECORDS

TO BE SENT TO YOUR PHYSICIAN PRIOR TO YOUR FIRST APPOINTMENT

(Please* do not *return this form with your other paperwork)

PHYSICIAN:____________________________PHONE: ______________________

ADDRESS:____

CITY:_________________________________STATE:_ZIP: __________________

PATIENT'S NAME:____

DOB:_______________________SOCIAL SECURITY NUMBER: XXX-XX-_________

DATE OF APPOINTMENT: ____

The above named patient is now being seen in our office and has informed us of treatment in your facility. We are particularly interested in information regarding:

____

____

Please send to the address indicated below:

The Fertility Center

____3230 Eagle Park Dr. NE, Suite 100	____317 S. Drake Rd., Suite B
Grand Rapids, MI 49525	Kalamazoo, MI 49009
Fax 616-988-2010	Fax 269-324-5041

PATIENT AUTHORIZATION FOR RELEASE OF INFORMATION

This is to certify that I hereby authorize you to release information requested to The Fertility Center. Information may be released with the following exceptions:

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I understand there is a possibility the information may be re-disclosed by the recipient and no longer protected under the federal privacy rules. I understand this is an optional form and my refusal to sign it will not affect my ability to obtain treatment and I may obtain a photocopy of this form on request. This release is effective for 6 months from today's date.

SIGNATURE:__________________________________**DATE:** ____________________

Witnessed by:____

Relationship to patient:____