The Fertility Center

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REQUEST FOR RELEASE OF MEDICAL RECORDS TO A PATIENT

PATIENT NAME: _____ PHONE: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

DOB: _____ SOCIAL SECURITY NUMBER: _XXX-XX-_____

DATE RANGE OF RECORDS

REQUESTED:_____

I understand there is a possibility the information may be re-disclosed by the recipient and no longer protected under the federal privacy rules. This release is effective for 6 months from today's date.

SIGNATURE: _____ DATE: _____

RELATIONSHIP TO PATIENT: _____

WITNESS: _____

Charge $35.00

Date Paid: _____

Check/Cash/Credit Card