Authorization for Release of Confidential Medical Records

Patient Name: _____
Address: _____
_____
Date of Birth: _____ SSN: _____

This authorizes DFW Fertility Associates
To release the following medical records on _____
(patient name)

TO: (NAME, ADDRESS & TELEPHONE NUMBER)
_____
_____
_____

_____ History/Progress Notes _____ Lab Reports _____ Surgical Reports

_____ HIV Test Results _____ X-Rays _____ Mental Health

_____ Other (please specify_____

This authorization covers patient care from _____ to _____
(date) (date)

Purpose of disclosure:
_____Medical Care
_____Insurance
_____Other (please specify) _____

This authorization shall be valid for 120 days from the date of signature. The patient can revoke this authorization in writing at any time prior to the expiration date.

The patient agrees that a photocopy of this authorization may be considered valid:
_____Yes _____No

Patient's Signature_____

Date _____