FORT WORTH FERTILITY

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DIPLOMATE OF THE AMERICAN BOARD OF OBSTETRICS AND GYNECOLOGY AND THE SUBSPECIALTY BOARD OF REPRODUCTIVE ENDOCRINOLOGY AND INFERTILITY

PHONE: 817-348-8145
FAX: 817-348-8264

Authorization for Release of Confidential Medical Records

Patient Name: _____ SS#:_____

Date of Birth: _____

I authorize the following individual or organization to disclose personal health information on the Individual listed above:

_____ Address: _____

The information may be disclosed TO the following individual or organization:

___ _____ _____ ___ Address: _____

The following may be released:

_____History & Physical
_____Progress Notes
_____Stimulation Cycles
_____HIV Test Results
_____Hepatitis Information
_____ Lab Results from (date) _____to (date) _____
_____Semen Analysis
_____Operative Note/ Report
_____ Pathology Reports
_____X-Rays
_____ HSG Films & Report
_____ Mental Health
___X__ALL RECORDS
_____Other (**please specify**) _____

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

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.

I agree that a photocopy of this authorization may be considered valid: _____Yes _____No

Patient/ Legal Guardian_____ Date: _____