



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:

- | | |
|--|--|
| <input type="checkbox"/> History & Physical | <input type="checkbox"/> Operative Note/ Report |
| <input type="checkbox"/> Progress Notes | <input type="checkbox"/> Pathology Reports |
| <input type="checkbox"/> Stimulation Cycles | <input type="checkbox"/> X-Rays |
| <input type="checkbox"/> HIV Test Results | <input type="checkbox"/> HSG Films & Report |
| <input type="checkbox"/> Hepatitis Information | <input type="checkbox"/> Mental Health |
| <input type="checkbox"/> Lab Results from (date) _____ to (date) _____ | <input checked="" type="checkbox"/> ALL RECORDS |
| <input type="checkbox"/> Semen Analysis | <input type="checkbox"/> 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: _____