Authorization Release Of Medical Records

Date:____________

I hereby authorize my medical records to be released to:

Please mark next to your clinic location.

________ Aventura Fertility & IVF Center ________ Palm Beach Fertility Center (Boca Raton)

I would like my information sent VIA: (Please Cicle)

(Fax) (Email) (Mail)

Phone/Fax or Address:

I would like the following information released:
(Please Circle)

(Labs) (Progress Notes) (Operative Notes) (OB Records) (All Records)

Other:____

Reason For Release:

_____ Moving out of area _____Personal Record _____ 2nd Opinion _____Graduating

_____Transferring to another Physician _____ HIV/AIDS Results (Available Upon Request Only)

I understand that if I request records to be sent to myself there is a fee of $1.00 for each page for the first 25 pages, any pages that exceed 25 pages, I will be charged an additional $0.25 for each page after. *There is no fee to transfer records to another physician*

Patient Printed Name:_______________________________________ Date Of Birth:____________
Patient Signature:____

Phone Number:____