Authorization To Release Medical Records to Our Office

Date:_____

I hereby authorize the following facility:

_____

To release my medical records to:

_____Aventura Fertility & IVF Center

_____ Palm Beach Fertility Center

Fax Number: (561) 477-7035

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

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

Other:_____

By using my signature below, I authorize your facility to send my records to my fertility center listed above.

_____

Patient Printed Name:_____ Date Of Birth:_____

Patient Signature:_____

Phone Number:_____