PALM BEACH FERTILITY CENTER
MARK DENKER, M.D.

AUTHORIZATION TO RELEASE MEDICAL RECORDS (FROM)

DATE: _____

I hereby authorize Palm Beach Fertility Center to release my medical records to:

_____

_____

_____

By Fax _____ By Mail _____ (Circle One)

Describe the information you want to be released, such as labs, progress notes, operative notes, etc.

_____

_____

_____

REASON FOR RELEASE:

_____ Transferring to another physician _____ Insurance change _____ Moving out of area

_____ 2nd Opinion _____ HIV/AIDS results (available upon request only)

_____ Other _____

Send record to another doctor for my continued care. There is no charge for records sent to another physician.

Doctor's Name:_____ Doctor's Fax Number:_____

I understand that the fee for copying records and electronically mailed (email) records is $1.00 per page for the first 25 pages and the .25 for each page thereafter.

PRINT NAME: _____

SIGNATURE: _____

HOME PHONE: _____ CELL PHONE:_____