PALM BEACH FERTILITY CENTER
MARK DENKER, M.D.

AUTHORIZATION TO RELEASE MEDICAL RECORDS (TO)

DATE: ___________________

I hereby authorize: ____
(Physician Name and/or Facility Name)

to release my medical records to PALM BEACH FERTILITY CENTER Via FAX or MAIL (Circle One)

PALM BEACH FERTILITY CENTER
7015 Beracasa Way. Suite 201
Boca Raton, Florida 33433
Ph. 561-477-7728 Fax 561-477-7035

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

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PRINT NAME: ____

SIGNATURE: ____

HOME PHONE: ____

CELL PHONE: ____