REQUEST FOR RELEASE OF MEDICAL INFORMATION

PLEASE RETURN A COPY OF THIS FORM WITH RECORDS BY _______________.
THANK YOU

I hereby authorize: ____
(Doctor's Name or Medical Group)

Address: ____
____
____

TO RELEASE ANY AND ALL RECORDS OR A SUMMARY OF FINDINGS AND RECOMMENDATIONS WITH PARTICULAR REFERENCE TO INFERTILITY AND/OR ANY GYNECOLOGICAL OR HORMONAL PROBLEM.

***PLEASE RELEASE FILMS TO PATIENT SO THEY CAN BRING THEM TO THEIR VISIT. FILMS WILL BE RETURNED TO PATIENT AT THE END OF THE VISIT.

Send Information to: Department of Obstetrics and Gynecology
Division of Reproductive Endocrinology and Infertility
Stanford Medical Center
900 Welch Road, Suite 350
Stanford, CA 94304
(650) 498-7911

^^^

Regarding:

Patient's Name:____

Former Name: ____

Birthday: ____

Approximate date of care:_________________________________

The authorization shall become effective immediately and shall expire six months from this date unless indicated otherwise or revoked earlier in writing. I understand that this information cannot be further released without my specific written consent. No further authorization upon my request

____ ____________________
Patient, Parent, Guardian or Legal Representative Signature

<u>*PATIENT: PLEASE COMPLETE THIS FORM, SIGN AND DATE AND SEND DIRECTLY TO THE LOCATION(S) OF YOUR RECORDS</u>.**