Astra Fertility Clinic

AUTHORIZATION TO RELEASE MEDICAL RECORDS

Date: _____

To: DR. _____
_____
_____
_____

FAX #: _____

Re:

AFIX PT. LABEL

Please forward the following information:

Laparoscopy Report
Semen Analysis Report
HSG/Dye Test Results
Ultra Sounds
Previous I.V.F. Results
Previous S.T.I.M. Sheets
Hysteroscopy Report
O.R. Reports

I hereby authorize you to release any information including the diagnosis and records of any treatment or examination rendered to me during the period of time that I was under your care.

_____ _____
Signature of Patient Signature of Patient's Partner

_____ _____
Witness Witness