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BRIAN D. BARNETT, M.D. • LOWELL T. KU, M.D.
DARA L. HAVEMANN, M.D. • SARA J. MUCOWSKI, M.D.

Medical Records Release Authorization

This form can be used for you to send to your OB/GYN or previous treating physician to request your medical records.

Doctor: _____

Address: _____

Fax: _____

I authorize and request you to release to:

Dallas IVF - Frisco
F: (214) 297-0025

Dallas IVF - McKinney
F: (469) 219-8201

Dallas IVF - Plano
F: (469) 429-4646

Dallas IVF - Tyler
F: (903) 865-7445

Dallas IVF - Dallas
F: (214) 423-4031

Please forward my complete medical history records in your possession concerning my illness and/or treatment during the period from _____ to _____. My appointment is on _____ (date).

Records to include:

- ❖ Any infertility testing or treatment
- ❖ Embryology reports (if patient has previously undergone IVF)
- ❖ Records related to pregnancy losses
- ❖ Any current (within one year) infectious disease screening
- ❖ Most recent PAP smear results
- ❖ Any genetic testing
- ❖ Sperm testing completed on my partner

Name: _____ Date of Birth: _____

Address: _____

Signature: _____ Date: _____

Please be kind to the environment. If there are more than 30 pages, please send in the mail. Thank you!

Frisco: 2840 Legacy Dr. Suite 100, Frisco, TX 75034

McKinney: 5301 W. University Drive, McKinney, TX 75071

Plano: 3000 Communications Pkwy Suite 200, Plano, TX 75093

Tyler: 641 South Broadway, Tyler, TX 75701

Dallas: 3600 Gaston Ave, Barnett Tower, Suite 1001, Dallas, TX 75246

P: (214) 297-0020 F: (214) 297-0025

P: (469) 219-8210 F: (469) 219-8201

P: (469) 429-2640 F: (469) 429-4646

P: (903) 865-0154 F: (903) 865-7445

P: (214) 423-4032 F: (214) 423-4031