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Authorization to Release Medical Records

This form can be used to request your medical records to be sent to yourself or another physician.

Patient Name: ____ DOB: __________________

Address: ________________________________City:_______________State:_______Zip:_________

Phone: (____)____________________________ Email: ____________________________________

I authorize the release of my medical records from Dallas IVF to: ☐ Self/Same as above

Name: ____

Address: _______________________________City:_______________State:_______Zip:___________

Fax: (____)______________________________Phone: (____)___________________________________

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
- ❖ Any genetic testing
- ❖ Semen Analysis, if applicable
- ❖ _________________________________

By signing below you indicate that:

You understand that there is a material cost fee of $25 for the medical records. Payment is due upon receipt of signed request. Records can be mailed or picked up at one of our facilities. There is no charge to send pregnancy sonogram report(s) to your obstetrician.

This signed release is valid for 120 days from the date of signature; however, you may cancel/revoke this authorization any time prior to that date by submitting a written request.

Patient Signature: ____

Date Requested: ____

Medical Records Request Credit Card Authorization Form

Patient name (print): ____Date of Birth: ________________

Name on card: ____

Billing address: ____ City, State, Zip: ___________________

Credit card No: ____ Exp: _______________