Dallas IVF
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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: _____