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MEDICAL RELEASE

REQUEST FOR RELEASE OF MEDICAL RECORDS, DIAGNOSIS, HISTORY, MEDICAL INFORMATION, X-RAYS, ULTRASOUNDS, LABORATORY TESTING, AND PAST MEDICAL HISTORY

I HEREBY REQUEST THAT **CHA FERTILITY CENTER RELEASE MY MEDICAL RECORDS TO:**

PRINT PATIENT NAME: DATE OF BIRTH:

PATIENT'S ADDRESS:

CITY, STATE, ZIP CODE

PATIENT'S PHONE: PATIENT'S FAX:

***MEDICAL RECORD RELEASE TO*:** (PLEASE CHECK)

- ◯ PICK UP
- ◯ FAX TO ABOVE FAX NUMBER
- ◯ MAILED TO ABOVE ADDRESS
- ◯ DOCTOR'S OFFICE: DOCTOR'S NAME/OFFICE: _____

DOCTOR'S FAX: _____

DOCTOR'S PHONE: _____

PATIENT SIGNATURE DATE