980 Raintree Circle, Allen, TX 75013

Phone (214) 383-2600 Fax (214) 383-2601

Authorization to Disclose Protected Health Information

Patient name: ____ DOB: ___________________

address: _______________________________________ City: ____________________ State ________ ZIP _______________

phone number: (_____)________________

I hereby authorize and request

Dr. name/Facility name: ____

address: _______________________________________ City: ____________________ State ________ ZIP _______________

phone number: (_____)________________ Fax number: (_____)________________

To release the following information to:

DFW Center for Fertility and IVF

980 Raintree Circle, Allen, Texas 75013

(214) 383-2600 (phone) (214) 383-2601 (fax)

Please check one:

☐ Entire medical record

☐ Initial fertility evaluation and relevant fertility testing results

☐ Other: ____

Reason for disclosure:

☐ Treatment/continued medical care

☐ Other: ____

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: ______________________