FW CENTER FOR FERTILITY & IVF
980 Raintree Circle, Allen, TX 75013
Phone (214) 383-2600 Fax (214) 383-2601

Authorization to Release Medical Records

Patient name: _____ DOB: _____

address: _____ City: _____ State _____ ZIP _____

phone number: (____)_____

Records to be sent to:

Name: _____

address: _____ City: _____ State _____ ZIP _____

phone number: (____)_____ Fax number: (____)_____

Please check one:

☐ Entire medical record

☐ Initial fertility evaluation and relevant fertility testing results

☐ Pregnancy sonogram reports (no charge)

☐ Other: _____

By signing below, you indicate that:

You understand that there is a material cost fee of $20 for the first 20 pages of records, afterwards $0.50 will be charged for each additional page. Prior to record release you will be informed of the total amount. Records will be mailed within one week of receipt of payment.

There is no charge to send pregnancy sonogram reports and images 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: _____