Lucile Salter Packard Children's Hospital

Stanford MEDICINE
Fertility and Reproductive Health

900 Welch Road, Suite 350 • Palo Alto, CA 94304 • Tel: (650) 498-7911 • Fax: (650) 498-6175

REQUEST FOR RELEASE OF MEDICAL INFORMATION

Please return a copy of this form with records by _____.

Thank you.

Patient: Please complete this form, sign and date and send directly to the location(s) of your records. Please make photocopies of this form if needed for multiple locations.

Physician or Medical Group: Please send medical records and/or a summary of findings and recommendations with particular reference to infertility and/or any gynecological or hormonal problem to:

Stanford Fertility & Reproductive Health
900 Welch Road, Suite 350, MC 5800
Palo Alto, CA 94304-5800
PH: (650) 498-7911
FAX: (650) 498-6175

Films: Please release films to patient so they can bring them to their visit. Films will be returned to patient at the end of the visit.

Patient's Name: _____

Former Name: _____

Date of Birth: _____

Approximate Date of Care: _____

I hereby authorize: _____ to release any and all
(Doctor's Name or Medical Group)
records or a summary of findings and recommendations with particular reference to infertility and/or any gynecological or hormonal problem.

The authorization shall become effective immediately and shall expire six months from this date unless indicated otherwise or revoked earlier in writing. I understand that this information cannot be further released without my specific written consent. No further authorization upon my request.

X _____ _____

Patient, Parent, Guardian or Legal Representative Signature — Date

_____

Print Name