Authorization to Release Medical Records

I hereby authorize **Troché Fertility Centers** to release medical records and data pertaining to:

Patient Name:	**Social Security:**
Date of Birth:	**Phone Number:**
Street Address:	**City, State, Zip Code:**

Please specify what records should be released:

- ❑ All records
- ❑ All records between the dates of _____ and _____.
- ❑ Records pertaining _____

_____

Please specify method of release:

❑ Pick-up

❑ Fax transmission

_____

Patient Signature at time of Pick Up

❑ Mail to:

Name: _____

Address: _____

City, State, and Zip: _____

Phone #: _____

Fax #: _____

I understand that I may revoke this authorization at anytime, except to the extent that action based on this authorization has already been taken. I also understand that I will be solely responsible for the Security and Privacy of this information once received. This consent will expire six (6) months from the date on which it is signed. We will fulfill two requests of your medical records at no charge, each additional request will be subject to a $25 charge.

Patient's Name: _____

Signature: _____ Date: _____

Internal use only:

Completed By: _____ Date Records Mailed/Picked-up: _____
Obtain Signature at time of Pick Up___ Identification__ Personal __ ID# _____ Type_____