Authorization to Release Medical Records

I hereby authorize:

Practice Name:	**Doctor Name:**
Address:	**City, State, Zip:**
Phone Number:	**FAX Number:**

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 to _____

_____

Release records to:

Troche Fertility Centers

17612 N. 59th Avenue, Suite 100

Glendale, AZ 85308

(602) 993-8636

FAX # (602) 993-2528

I understand that I may revoke this authorization at anytime, except to the extent that action based on this authorization has already been taken. This consent will expire six (6) months from the date on which it is signed.

Patient's Name: _____

Signature: _____ Date: _____

Internal use only:

Completed By: _____
Date Records Mailed/Picked-up: _____