Fertility Specialists Medical Group/ San Diego Center for Reproductive Surgery
8010 Frost Street, Suite P
San Diego, CA 92123
(858)505-5500 Fax (858)505-5555

Authorization to Request Medical Records

This authorization to release medical information is in accordance to the Confidentiality of Medical Information Act of 1981, Section 56 et seq, of the California Civil Code.

I hereby authorize:

Name____

Address ____

Phone _________________________________ Fax ____

to release my records to Fertility Specialists Medical Group/San Diego Center for Reproductive Surgery.

Please release my medical records for an appointment on _____ /_____ /_____, including:

□ All medical records, including HIV testing

□ Please include ONLY: ____

□ Please exclude: ____

I give you permission to: □ Fax □ Mail □ I will hand carry

Patient Label or
Name
____
DOB _____/_____/_____

Signature ____

Date _____ /_____ /_____

Please also send any medical records pertaining to my partner □ including □ excluding HIV testing.

Patient Label or
Name
____
DOB _____/_____/_____

Signature ____

Date _____ /_____ /_____