

# Authorization to Release Medical Records

**NOTE TO NEW PATIENT: PLEASE SEND OR FAX THIS COMPLETED FORM TO YOUR PREVIOUS DOCTOR SO THAT HE/SHE CAN RELEASE A COPY OF YOUR MEDICAL RECORDS TO US PRIOR TO YOUR APPOINTMENT.**

**THANK YOU!!**

I hereby authorize \_\_\_\_\_ to release medical records and data pertaining to:  
(Doctor's Name/Practice)

<b>Patient Name:</b>	<b>Social Security:</b>
<b>Date of Birth:</b>	<b>Phone Number:</b>
<b>Street Address:</b>	<b>City, State, Zip Code:</b>

*Please specify what records should be released:*

All records

All records between the dates of \_\_\_\_\_ and \_\_\_\_\_.

Records pertaining to \_\_\_\_\_

\_\_\_\_\_

*Please specify method of release:*

Pick-up

Fax transmission

Mail to:

Mail to:

**Vladimir Troche, MD**

**West Valley Fertility Center**

17612 N. 59<sup>th</sup> Avenue, Suite 100

Glendale, AZ 85308

Phone: (602) 993-8636

Fax: (602) 993-2528

Name: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_

State: \_\_\_\_\_ Zip: \_\_\_\_\_

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: \_\_\_\_\_