Request to Transfer Medical Records to Pacific Fertility Center

Please type or print legibly in blue or black ink

Send this to the doctor or medical facility that has your medical records

To: ____
(Name of current or previous physician, medical group or clinic)

I, the undersigned patient, request a copy of my medical records:

Name:____

Address: ____
(Street address, including apartment or unit number)

____
(City, state, and zip code)

Date of Birth:________________ Social Security No.: _______________________

Patient ID# (if applicable): ____

Daytime phone:___________________ Evening phone: ______________________

Please release the requested information to:

Pacific Fertility Center
Attn: New Patient Guides
55 Francisco Street, Suite 500
San Francisco, CA 94133
Fax: (415) 834-3080

Appointment date:____________________________ Physician:______________

Please process this request within 15 calendar days, as provided by law. This authorization shall be valid for 90 days from the date of my signature below. A copy of this authorization form shall be deemed as valid as an original.

I hereby authorize you to furnish the medical information requested to Pacific Fertility Center, including the results of laboratory tests for infectious disease, if applicable.

______________________________ Date: ____________________________
Patient's signature

I, (please print) __________________________________, hereby authorize you to release any of my medical information contained in my partner's chart, including the results of laboratory tests for infectious disease, if applicable.

______________________________ Date: ____________________________
Partner's signature