SOUTHWEST FERTILITY CENTER
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RECORDS RELEASE AUTHORIZATION

RELEASE RECORDS TO :	RELEASE MEDICAL RECORDS FROM:
_____	_____
_____	_____
_____	_____
PHONE #_____	PHONE :_____
FAX # _____	FAX: _____

RECORDS NEED TO ARRIVE PRIOR TO PATIENT'S APPOINTMENT ON:

I hereby authorize the release of photocopies of the following medical records and /or x-ray films in the possession or control of the above named medical facility, its employees and /or agents. For the purposes hereof, "medical records" and "x-ray films" shall include all confidential HIV-related information (as defined in A.R.S. Section 36-661), confidential communicable disease-related information(as defined in A.R.S. section 36-661). Confidential alcohol or drug abuse-related information (as defined in 42 CFR section 2.1 ET SEQ.), and confidential mental health diagnosis/treatment information.

☐ HSG X-RAY REPORT	☐ HSG X-RAY FILMS	☐ LAB REPORTS
☐ ULTRASOUNDS	☐ LAPAROSCOPY REPORT	☐ PAP SMEAR RESULTS
☐ ANY GYN SURGERIES	☐ GYN RECORDS ONLY	☐ ALL MEDICAL RECORDS
☐ SEMEN ANALYSIS	☐ SPOUSE RECORDS	☐

PLEASE GIVE SPECIFIC REASON FOR RECORDS TRANSFER:

Patient's Name and Address: (please print, include previous last name change)	Date of Birth:_____
_____	Social Security Number:_____
_____	Phone Number:_____
_____	SPOUSE NAME:_____

Patient's Signature:	Date:
Witness Signature:	Date

There will NOT be a charge for the 1st copy of medical records for personal use. All copies thereafter will incur a $30 fee.
No charge for copies released directly to another physician