The Fertility Center

William Dodds MD, James Young MD, Valerie Shavell MD, and Richard Leach MD

3230 Eagle Park Dr. NE, Suite 100
Grand Rapids MI 49525
616.988.2229
877.904.4483

1100 S. Cedar St., Suite 2
Mason, MI 48854
877.904.4483

317 S. Drake Rd., Suite B
Kalamazoo MI 49009
269.324.5100
877.500.1658

REQUEST FOR RELEASE OF MEDICAL RECORDS
TO BE SENT TO YOUR PHYSICIAN PRIOR TO YOUR FIRST APPOINTMENT
(Please* do not *return this form with your other paperwork)

PHYSICIAN: _____ PHONE: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

PATIENT'S NAME: _____

DOB: _____ SOCIAL SECURITY NUMBER: _____

DATE OF APPOINTMENT: _____

The above named patient is now being seen in our office and has informed us of treatment in your facility. We are particularly interested in information regarding:

_____

_____

Please send to the address indicated below:

The Fertility Center

___ 3230 Eagle Park Dr. NE, Suite 100
Grand Rapids, MI 49525
Fax 616-988-2010

___ 317 S. Drake Rd., Suite B
Kalamazoo, MI 49009
Fax 269-324-5041

PATIENT AUTHORIZATION FOR RELEASE OF INFORMATION

This is to certify that I hereby authorize you to release information requested to The Fertility Center. Information may be released with the following exceptions:

_____

I understand there is a possibility the information may be re-disclosed by the recipient and no longer protected under the federal privacy rules. I understand this is an optional form and my refusal to sign it will not affect my ability to obtain treatment and I may obtain a photocopy of this form on request. This release is effective for 6 months from today's date.

SIGNATURE: _____ DATE: _____

Witnessed by:_____

Relationship to patient:_____