Authorization to Release Medical Records

I hereby authorize **Troché Fertility Centers** to release medical records and data pertaining to:

Patient Name:	**Social Security:**
Date of Birth:	**Phone Number:**
Street Address:	**City, State, Zip Code:**

Please specify what records should be released:

- ☐ All records
- ☐ All records between the dates of ___________ and _____________.
- ☐ Records pertaining ____

____

Please specify method of release:

☐ Pick-up

☐ Fax transmission

____

Patient Signature at time of Pick Up

☐ Mail to:

Name: ____

Address: ____

City, State, and Zip: ______________________________________

Phone #: ____

Fax #: ____

I understand that I may revoke this authorization at anytime, except to the extent that action based on this authorization has already been taken. I also understand that I will be solely responsible for the Security and Privacy of this information once received. This consent will expire six (6) months from the date on which it is signed. We will fulfill two requests of your medical records at no charge, each additional request will be subject to a $25 charge.

Patient's Name: ____

Signature: ______________________________ Date: ________________

Internal use only:

Completed By: ________________________ Date Records Mailed/Picked-up: ________________
Obtain Signature at time of Pick Up___ Identification__ Personal __ ID# ______________ Type______