



ADVANCED REPRODUCTIVE CARE CENTER, P.A.

Specialists in Reproductive Endocrinology and Infertility
Sy Q. Le, M.D. Derek A. Haas, M.D.
www.ivfmd.net

MEDICAL RECORD RELEASE AUTHORIZATION

Patient's Name _____ D.O.B. _____

Address _____

City _____ State _____ Zip _____ SS# _____

Before signing authorization for the release of my medical record, I acknowledge the following:

1. I understand that there will be a charge for labor and material cost in photocopying my medical record (\$25 for the first 20 pages and \$0.50 for each additional page). I will be notified of the total amount and will pay this fee before my record is released.
2. I understand that my medical record will be mailed within one week after payment is received.

I have read and agreed with the above conditions and authorize:

ADVANCED REPRODUCTIVE CARE CENTER, P.A.
SY Q. LE M.D. & DEREK A. HAAS M.D.

to release the following information to:

Name _____

Address _____

City _____ State _____ Zip Code _____

Phone _____ Fax _____

- Check all that may be released: Entire record
 Infertility notes & relevant studies only
 Other, please specify _____

This authorization shall be valid for 120 days from the date of signature. The patient can revoke this authorization in writing any time prior to the expiration date.

Patient's Signature _____ Date: _____