

# ADVANCED REPRODUCTIVE CARE CENTER OF IRVING

## AUTHORIZATION FOR DISCLOSURE OF CONFIDENTIAL INFORMATION

Patient's Name: \_\_\_\_\_

Address: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ SS#: \_\_\_\_\_

### I hereby authorize and request:

Doctor's Name: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

To release the following information to:

**Sy Q Le, MD or Derek A Haas, MD**

Please choose one location:

**Irving Office**  
**7501 Las Colinas Blvd, Ste 200**  
**Irving, TX 75063**  
**Fax: 972-506-0044**

**Arlington Office**  
**919 West Randol Mill Rd**  
**Arlington, TX 76012**  
**Fax: 817-701-1297**

- Check All That May be Released:

Infertility Notes & Relevant Studies Only

Other Please Specify: \_\_\_\_\_

- Purpose of Disclosure

Infertility Evaluation

Other: \_\_\_\_\_

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: \_\_\_\_\_

Witness: \_\_\_\_\_