

# Astra Fertility Clinic

## AUTHORIZATION TO RELEASE MEDICAL RECORDS

Date: \_\_\_\_\_

To: DR. \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

FAX #: \_\_\_\_\_

Re:

AFIX PT. LABEL

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**Please forward the following information:**

**Laparoscopy Report  
Semen Analysis Report  
HSG/Dye Test Results  
Ultra Sounds  
Previous I.V.F. Results  
Previous S.T.I.M. Sheets  
Hysteroscopy Report  
O.R. Reports**

I hereby authorize you to release any information including the diagnosis and records of any treatment or examination rendered to me during the period of time that I was under your care.

\_\_\_\_\_  
Signature of Patient

\_\_\_\_\_  
Signature of Patient's Partner

\_\_\_\_\_  
Witness

\_\_\_\_\_  
Witness