



REQUEST/RELEASE FOR MEDICAL RECORDS

I hereby authorize the release of all my records and test results, including HIV test results, in your possession regarding my illness and/or treatment for the period indicated:

All available records Past 12 months from _____ to _____
*Please be sure to include all operative reports or name of facility where reports can be obtained.

Please specifically include the following items:

1. _____
2. _____
3. _____

To From

Advanced Fertility Care, PLLC

All Mail and Fax Correspondence should be directed to:

**9819 North 95th Street, Suite 105
Scottsdale, AZ 85258
Phone: (480) 874-2229
Fax: (480) 874-2231**

To From

NAME/MEDICAL FACILITY:
ADDRESS:
CITY, STATE, ZIP CODE:

I release you, your physicians, and employees from liability for following this authorization and request. I understand that it may take up to 15 business days for completion of this transaction.

I understand that it is the policy of this office (Advanced Fertility Care) to release medical records directly to the patient. The fees charged by this office are set by the Arizona State Board of Medical Examiners. The first request for medical records is at no charge. Subsequent requests will be assessed a fee.

Patient Printed Name:	DOB:	Date:
PATIENT/LEGAL GUARDIAN SIGNATURE	WITNESS SIGNATURE	

Scottsdale
9819 North 95th St., Ste. 105
Scottsdale, AZ 85258
Tel (480) 874-BABY
Fax (480) 874-2231

South East Valley
2055 East Southern Ave., Ste. E
Tempe, AZ 85282
Tel (480) 413-BABY
Fax (480) 413-2228