



**IVF FLORIDA
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PATIENT CONSENT TO RELEASE MEDICAL RECORDS/LABORATORY TESTS

I authorize the release of medical information to the individual(s) noted below:

1. NAME OF PATIENT-- PLEASE PRINT

2. SOCIAL SECURITY NUMBER

3. My lab results may be released to my partner Yes No

4. Medical information may be released to my past or future treating physician Yes No

5. Physician's Name and Address

6. Medical information/lab results may be released to another person or party (please list).

1. NAME OF PARTNER (IF RELEVANT) – PLEASE PRINT

2. SOCIAL SECURITY NUMBER

3. My lab results may be released to my partner Yes No

4. Medical information may be released to my past or future treating physician Yes No

5. Physician's Name and Address

6. Medical information/lab results may be released to another person or party (please list).

SIGNATURE

DATE

SIGNATURE

DATE

WITNESS
Revised 2/09

DATE

WITNESS

DATE