



**IVF FLORIDA
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PATIENT: FAX OR MAIL THIS FORM TO YOUR PREVIOUS PHYSICIAN

MEDICAL RELEASE AUTHORIZATION

NAME _____

DATE OF BIRTH _____

SOCIAL SECURITY NUMBER _____

I HEREBY AUTHORIZE AND REQUEST THAT YOU RELEASE TO:

IVF Florida Reproductive Associates
2960 N. State Road 7, Suite 300
Margate, FL 33063
Fax: (954) 247-6262

600 Heritage Drive
Suite 200
Jupiter, FL 33458
Fax: 561 354-1526

- My complete medical history Laboratory reports only Operative reports
- Pathology reports X-rays
- Clinic notes concerning my illness and/or treatment during the period from _____ to _____

Signature

Date

Signature of Witness

Date