



**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).  
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\_\_\_\_\_  
SIGNATURE DATE

\_\_\_\_\_  
SIGNATURE DATE

\_\_\_\_\_  
WITNESS DATE  
Revised 3-10

\_\_\_\_\_  
WITNESS DATE