

***Request for Release of Medical Records***

**To:**

Physician's name \_\_\_\_\_

Address \_\_\_\_\_

City/State/Zip \_\_\_\_\_

Phone \_\_\_\_\_

Fax \_\_\_\_\_

*I hereby request that my medical records be released to:*

**Palmetto Fertility Center of South Florida  
Michael D. Graubert, M.D.  
7100 W. 20<sup>th</sup> Ave. Suite 205  
Miami, FL 33016  
Phone. (305) 558-0808  
Fax (305) 558-0806**

*I understand these records contain information from other health care providers, as well as information which is administrative in nature. I specifically consent in the release of any information contained in the medical records which may relate to infection with Human Immunodeficiency Virus, HIV, AIDS or related conditions.*

Patient name \_\_\_\_\_

Date of birth \_\_\_\_\_ Social security number \_\_\_\_\_ -- \_\_\_\_\_ -- \_\_\_\_\_

Patient signature \_\_\_\_\_ Date \_\_\_\_\_

**Please send the following results:**

- All medical records**
- PAP Smear and Cervical cultures**
- Laboratory Bloodwork**
- Hysterosalpingogram results**
- Pelvic ultrasound results**
- Semen analysis results**
- IVF laboratory and embryo**
- IVF stimulation sheets**

**Other:**