

Request for Copy or Transferring of my Medical Records

From:

Palmetto Fertility Center of South Florida
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To my Home Address by MAIL _____ OR FAX _____

Address _____

City/State/Zip _____

Phone _____

Fax _____

To Physician:

Physician's name _____

Address _____

City/State/Zip _____

Phone _____

Fax _____

I hereby request that my medical records be released to:

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.

There will be a medical record fee for any records sent to you personally, or any request for hard copies of your records.

The fee is \$1.00 a page for the first 25 pages and \$0.25 for each additional page.

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: