

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:

**Michael D. Graubert, M.D.
Rafael A. Cabrera, M.D.
Palmetto Fertility Center of South Florida
7100 W. 20th 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: