2510 Wigwam Parkway Ste 201
Henderson, NV 89074
Phone: 702-722-2229
Fax: 702-778-7672

MEDICAL RECORDS RELEASE FORM

I,_____, DOB_____ and

_____, DOB_____

Hereby request that all of our medical records be released to my physician at the above address.

Requesting records from:

Physician's Name_____
Address_____
Phone_____Fax_____

Please include the following information:
Any lab work that has been performed within the last 18 months, including confidential testing such as:
FSH, Estradiol, Prolactin, TSH, Blood Type/PH factor, Rubella, Cystic Fibrosis, Varicella Zoster, Hepatitis A, B, & C, HIV 1&2, HTLV, CMV RPR, VDRL, Chlamydia, Gonorrhea, CBC, LH, MTHFR, Factor V Leiden, Testosterone, Glucose/Insulin tests, DHEAS, Semen Analysis with morphology, PAP smear, Mammogram and Chest X-ray.

Any of the following testing/procedures: Fluid Ultrasound, Hysterosalpingogram, Laparoscopy and Hysteroscopy.
Any information relating to all prior In Vitro Fertilization cycles and/or Intrauterine Inseminations.

Patient	Partner
Name:_____	Name:_____
Printed	Printed
Signature:_____	Signature:_____
Date	Date