



AUTHORIZATION TO RELEASE LABORATORY/MEDICAL RECORDS

I, _____, hereby authorize the Fertility Center of California (FCC) to release and furnish all my Medical/Laboratory records held at FCC.

Release To:

Address:

City:	State:	Zip Code/Country:
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Phone:	Fax:	Email:
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PATIENT INFORMATION

First Name:	Last Name:
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Current address:

City:	State:	Zip Code/Country:
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Phone (Day):	Phone (Eve):	Email:
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Driver's license#:	Date of Birth (mmdyyyy):
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Patient Signature:	Date:
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Witness Name:	Witness signature:
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FCC USE ONLY

FCC Representative:	Date Records released:
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