



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:

Phone:

Fax:

Email:

PATIENT INFORMATION

First Name:

Last Name:

Current address:

City:

State:

Zip Code/Country:

Phone (Day):

Phone (Eve):

Email:

Driver's license#:

Date of Birth (mmdyyyy):

Patient Signature:

Date:

Witness Name:

Witness signature:

FCC USE ONLY

FCC Representative:

Date Records released: