Texas Fertility Center

AUTHORIZATION FOR DISCLOSURE OF CONFIDENTIAL INFORMATION

Patient Name:_____

Date of Birth: ____/____/____ Social Security #: ____-____-____

Name:_____Relationship to Patient:_____

Date of Birth: ____/____/____ Social Security #: ____-____-____

I authorize the physicians and/or staff to release the following medical information between the above listed **patient and individual**.

Check all that may be released:

- ❑ History and Physical
- ❑ Progress Notes
- ❑ Lab Results
- ❑ Radiology Reports
- ❑ Operative Reports
- ❑ Semen Analysis
- ❑ Prescriptions
- ❑ Financial Issues
- ❑ Complete medical history including the above listed information
- ❑ _____

_____	_____	_____
Patient Name (Printed)	Patient Signature	Date
_____	_____	_____
Partner Name (Printed)	Partner Signature	Date