Zouves Fertility Center

Request to Transfer Medical Records

Please type or print legibly

Forward this request to your physician

To:_____
(Name of the physician or medical group)

I, the undersigned patient, request a copy of my medical records:

Name:_____

Address:_____
(Street address, including apartment or unit number)

_____
(City, State, Zip Code)

Date of birth:_____Social Security number:_____

Patient ID# (if applicable)_____

Daytime phone number:_____ Evening phone number:_____

Release the requested information to the below address:

_____

_____

_____

Please process this request within 15 calendar days, as provided by law.

This authorization shall be valid for ninety (90) days from the date of my signature below.

A copy of this authorization form shall be deemed as valid as an original.

_____ Date:_____
Patient Signature

_____ Date:_____
Spouse's Signature