Procreate
Fertility Center of Virginia

MEDICAL RECORDS FAX: 877-296-5848

REFERRAL FAX (5 Pages or less): 757-451-9694

MEDICAL RECORDS RELEASE FORM

PATIENT INFORMATION:

NAME:_____ DOB:_____ SSN:_____

ADDRESS:_____

CITY: _____ STATE:_____ ZIP: _____

By signing this form, I authorize Procreate Fertility Center of Virginia to release confidential health information about me. Please select which information you would like released.

PLEASE RELEASE THE REQUESTED RECORDS **FROM** THE FOLLOWING ORGANIZATION:

Facility Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____

Records Requested:

ALL RECORDS

History and Physical

Progress Notes

Consultation Visits

Laboratory Results

Ultrasounds, Imaging, etc.

Surgical Reports

Other: _____

Patient Signature: _____ Date: _____

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