9817 N 95th St, Ste I-107, Scottsdale AZ 85258 * 6859 E Rembrandt Ave, Ste 111, Mesa AZ 85212

(602) 765-2229 * Fax (602)493-6641

IVFPhoenix.com

ART: RELEASE OF MEDICAL INFORMATION

Date: ___________________________

Patient name:____ Date of Birth: ______________________

Name at time of service (if different): ____

To (Name/Practice): ____

Address:____Phone: _____________________________

____ Fax: _______________________________

Please check all that are being requested:

- H & P, Physician notes
- ALL DOCUMENTS FOR ART CYCLES & RECORDS OF ALL CRYOPRESERVATION
- Ultrasounds
- SONOHYST/ HSG
- ART CYCLE FLOWSHEET & GENETIC REPORTS
- SURGICAL PROCEDURES inclusive of OP REPORTS
- All Blood Lab results
- Andrology Reports

OR

The following described records only (specify types and dates):

____

____

Please release my medical records to: **Dr. John Couvaras, MD of IVF PHOENIX**

Your prompt response is greatly appreciated.

Sincerely,

____ ____________________________

Patient's signature Date