COASTAL
FERTILITY SPECIALISTS
Because Your Dreams Matter.

Reproductive Endocrinology and Infertility

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AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

THIS FORM NEEDS TO BE SENT TO YOUR PHYSICIAN(S), NOT TO CFS
Please send this form to any physicians (OB/GYN, Urologist, Infertility Specialist. etc) who have participated in your fertility-related care ASAP.

Patient Name: _____
First Middle/Maiden Last

SS#: _____ DOB: _____

INFORMATION RELEASED FROM:	*INFORMATION RELEASED TO:*
PRACTICE NAME:	COASTAL FERTILITY SPECIALISTS
PHYSICIAN NAME:	ATTN: NEW PATIENT COORDINATORS
ADDRESS:	1375 HOSPITAL DRIVE
	MOUNT PLEASANT, SC 29464
PHONE:	PHONE: (843) 883-5800
FAX:	FAX: (843) 628-5880

Dear Dr. _____:

I am considering treatment at Coastal Fertility Specialists. Please forward a summary letter, this sheet, and the below listed information to Coastal Fertility Specialists. All records need to be submitted by appointment date: _____.

Please include the following if applicable:

- All semen analyses
- Hysterosalpingogram (HSG) reports and films
- Any operative notes and pathology
- ALL LAB RESULTS
- Any other pertinent records related to infertility including notes on IUI and IVF

I request and authorize the above-named physician or health care provider to release information to Coastal Fertility Specialists. I certify this request has been made voluntarily and that the information given above is accurate. I understand that I may revoke this authorization at any time, except to the extent that action has already been taken to comply with it. Re-disclosure of my medical records by those receiving the above authorized information may not be accomplished without my further written consent. Copies of medical records may be mailed or faxed to the above address.

Sincerely,

_____ _____
Signature Date

PLEASE ENCLOSE THIS LETTER WITH THE COPIES OF RECORDS