Sy Q Le, M.D.
Board Certified in Reproductive Endocrinology & Infertility

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MEDICAL RECORD RELEASE AUTHORIZATION

Patient's Name: _____D.O.B_____

Address: _____

City: _____State: _____ Zip: _____

I authorize: **IVFMD, P.A.**

to fax my medical record to:

Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone: _____ Fax: _____

Check all that may be released: ☐ Entire record

☐ Infertility notes & relevant studies only

☐ Other, please specify _____

This authorization shall be valid for 120 days from the date of signature. The patient can revoke this authorization in writing any time prior to the expiration date.

Patient's Signature: _____ Date:_____

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600 W Mayfield Rd Arlington, TX 76014 Tel 817-701-1290 Fax 817-701-1297