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

www.ivfmd.net

MEDICAL RECORD RELEASE AUTHORIZATION

Patient's Name: ____D.O.B_______________________________

Address: ____

City: _______________________State: ____________ Zip: _________________

Before signing authorization for the release of my medical record, I acknowledge the following:

1. I understand that there will be a charge for labor and material cost in photocopying my medical record ($25 for the first 20 pages and $0.50 for each additional page). I will be notified of the total amount and will pay this fee before my record is released.
2. I understand that my medical record will be mailed within one week after payment is received.

I have read and agreed with the above conditions and authorize:

IVFMD, P.A.
SY Q. LE M.D.

to release the following information 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:___________________________

7501 Las Colinas Blvd, Ste 200 Irving, TX 75063 Tel 972-506-9986 Fax 972-506-0044
600 W Mayfield Rd Arlington, TX 76014 Tel 817-701-1290 Fax 817-701-1297