LANE
fertility
institute

MEDICAL RECORDS RELEASE

Please send this directly to your previous physician:

To: _____

Address: _____

_____

From: _____

(Print your name)

_____

(Mailing address)

Date of Birth: _____ Date of my appointment: _____

Reason: **For Physician Consultation and Continued Care**

I hereby authorize and request you to release to Danielle E. Lane, M.D. my complete medical records in your possession, concerning my treatment, to include any and all history notes, progress notes, operative reports, lab/x-ray reports, physical exam notes, HSG films, all infectious screening lab reports, my HIV results and all other medical records.

The records should be sent directly to:

Lane Fertility Institute
101 Rowland Way, Suite 305
Novato, CA 94945
Telephone Number: 415-893-0391
Fax Number: 415-892-4455

This authorization is valid for ninety (90) days from the date of my signature below. A copy of this authorization form shall be deemed as valid as an original.

Please process this request within fifteen (15) calendar days as provided by law.

Signed: _____

Date: _____