IVF New England
Helping people become parents®

MEDICAL RELEASE FORM

Date: _____/_____/_____

Dear Physician,

Please forward all pertinent fertility information related to the treatment of your patient. Thank you.

- ☐ Copy of Semen Analysis
- ☐ Copy of History & Physical
- ☐ Copy of Hematocrit & Hemoglobin
- ☐ Copy of any hormonal labs drawn (FSH, E2, LH, TSH, Prolactin)
- ☐ Copy of genetic test results
- ☐ Copy of latest PAP smear
- ☐ Copy of ABO/RH blood type
- ☐ Any pertinent operative reports
- ☐ Copy of Chlamydia, HIV, Hep. B, Varicella, RPR, and Rubella
- ☐ _____

Patient Name: _____ DOB: _____/_____/_____

Address: _____

City: _____ State: _____ Zip Code: _____

Physician Name: _____

I hereby authorize you to release my medical records to:

IVF NEW ENGLAND
One Forbes Road
Lexington, MA 02421-7305
Attn: Medical Records Department
Fax: 781.674.1520

_____ _____
Patient Signature Date

Update: 10/15/2014