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This form can be used for you to send to your OB/GYN or previous treating physician to request your medical records.

Medical Records Release Authorization

Attention:

Doctor: _____

Address: _____

Fax: _____

I hereby authorize and request you to release to:

Frisco Fertility Center
2840 Legacy Drive, Suite 100
Frisco, TX 75034
Phone: (214) 297-0020
Fax: (214) 297-0025

McKinney Fertility Center
5301 W. University Drive
McKinney, TX 75071
Phone: (469) 219-8210
Fax: (469)-219-8201

Please forward my complete medical history records in your possession, concerning my illness and/or treatment during the period from _____ to _____. My appointment is on _____ (date).

Records to include:

- ❖ **Any infertility testing or treatment**
- ❖ **Embryology reports (if patient has previously undergone IVF)**
- ❖ **Records related to pregnancy losses**
- ❖ **Any current (within one year)infectious disease screening**
- ❖ **Most recent PAP smear results**
- ❖ **Any genetic testing**

Name: _____ **DOB:** _____

Address: _____

Signature: _____

Date: _____