Patient Authorization Form for Release of Records
Disclosure of Protected Health Information

Patient's Name:_____Date of Birth:_____

1. Persons or group of persons authorized to use/ disclose this information:

Doctor/Facility Name:_____

Facility Phone Number:_____**Facility Fax Number**:_____

2. Persons or group of persons authorized to receive this information:

Montgomery Fertility Center
3202 Tower Oaks Boulevard Suite 370
Rockville, MD 20852
Phone: (301) 946-6962 Fax: (301) 946-6022

3. Description of the information to be used or disclosed:

_____

_____

4. Reason for requesting the medical records or leaving this practice:

_____

_____

I authorize you to furnish medical records covering the period from (date) _____ to (date) _____. I release you from all legal responsibility or liability that may arise from the authorization.

_____
Patient Name Print

_____ _____
Patient Signature Date