

Astra Fertility Clinic

4303 Village Centre Court Miss. Ontario L4Z 1S2
• Tel: 905-949-6999
• Fax: 905-949-6908

AUTHORIZATION TO RELEASE MEDICAL RECORDS

Date: _____

To: DR. _____

FAX #: _____

Re:

AFIX PT. LABEL

Please forward the following information:

**Laparoscopy Report
Semen Analysis Report
HSG/Dye Test Results
Ultra Sounds
Previous I.V.F. Results
Previous S.T.I.M. Sheets
Hysteroscopy Report
O.R. Reports**

I hereby authorize you to release any information including the diagnosis and records of any treatment or examination rendered to me during the period of time that I was under your care.

Signature of Patient

Signature of Patient's Partner

Witness

Witness