Astra Fertility Clinic

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- 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