



IVF PHOENIX

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RELEASE OF MEDICAL INFORMATION

DATE: _____

PATIENT'S NAME: _____

Date of Birth: _____ Name at time of service: _____

TO: _____

Please release my medical records to:

IVF PHOENIX
Dr John Couvaras, M.D.
9817 N. 95th Street, Bldg I, Suite 105,
Scottsdale, AZ 85258

Your prompt response is greatly appreciated.

Sincerely,

Patient's Signature

Date