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IVFPhoenix.com

### ART: RELEASE OF MEDICAL INFORMATION

Date: \_\_\_\_\_

Patient name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Name at time of service (if different): \_\_\_\_\_

To (Name/Practice): \_\_\_\_\_

Address: \_\_\_\_\_ Phone: \_\_\_\_\_

\_\_\_\_\_ Fax: \_\_\_\_\_

**Please check all that are being requested:**

- H & P, Physician notes
- ALL DOCUMENTS FOR ART CYCLES & RECORDS OF ALL CRYOPRESERVATION
- Ultrasounds
- SONOBYST/ HSG
- ART CYCLE FLOWSHEET & GENETIC REPORTS
- SURGICAL PROCEDURES inclusive of OP REPORTS
- All Blood Lab results
- Andrology Reports

OR

The following described records only (specify types and dates):

\_\_\_\_\_  
\_\_\_\_\_

***Please release my medical records to: Dr. John Couvaras, MD of IVF PHOENIX***

Your prompt response is greatly appreciated.

Sincerely,

\_\_\_\_\_  
Patient's signature

\_\_\_\_\_  
Date