

AUTHORIZATION *for* RELEASE *of* PATIENT MEDICAL INFORMATION

ATTN: _____ Phone: _____

Date: _____

I hereby authorize the above party to release the following medical information to:



THE NEW HOPE CENTER *for* REPRODUCTIVE MEDICINE

ROBIN L. POE-ZEIGLER, M.D., F.A.C.O.G.

1181 First Colonial Road, Suite 100, Virginia Beach, VA 23454

Phone: (757) 496-5370 . Fax: (757) 481-3354

Patient Name: _____ Date of Birth: _____

SSN: _____ Phone: _____

Former name (if applicable): _____

Date last seen in your office: _____

This information should include, but not be limited to, the following records:

FEMALE

Operative reports
HSG reports and films
Flow sheets from ovulation induction and IVF cycles
Biopsy reports
Post-coital results
Hormonal studies (LH, FSH, TSH, Prolactin and DHEAS)

MALE

Semen analysis results
Antisperm antibody results
Urology: Operative reports

LAB TESTS, INCLUDING: Current pap, antisperm antibody results, rubella, etc.
OTHER: Any other records that pertain to this patient's treatment at your office.

This authorization may be cancelled by me in writing at any time.

Patient Signature (parent or guardian of minor) Date

Witness Date