



THE NEW HOPE CENTER  
*for* REPRODUCTIVE MEDICINE

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AUTHORIZATION *for*  
RELEASE *of* PATIENT MEDICAL INFORMATION

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

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

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

SSN.: \_\_\_\_\_ Phone: \_\_\_\_\_

Former name (if applicable): \_\_\_\_\_

Date of last office visit: \_\_\_\_\_

\_\_\_\_\_  
Patient Signature (parent or guardian of minor)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Witness Signature

\_\_\_\_\_  
Date