



Specialists In Reproductive Medicine & Surgery, P.A.

Craig R. Sweet, M.D.

Board Certified In Reproductive
Endocrinology & Infertility
and Obstetrics & Gynecology

Lorrie Posegay, A.R.N.P.

Advanced Registered Nurse Practitioner
Women's Care Specialist
ART Coordinator

Dedicated To Excellence In Reproductive Medicine

Patient Identifying & Contact Information (Please Print Clearly):

Name: _____ *You may contact me at any of the
phone numbers listed below:*

Address: _____

City: _____ Home Phone: (____) _____ - _____

State: _____ Zip: _____ Cell Phone: (____) _____ - _____

Date Of Birth: ____/____/____ Work Phone: (____) _____ - _____

Please Mail or Fax My SRMS Records To (Please Print Clearly):

Name/Facility: _____ Work Phone: (____) _____ - _____

Address: _____ Fax: (____) _____ - _____

City: _____ Contact: _____

State: _____ Zip: _____

Types of Medical Records To Be Sent (Check Those That Apply):

Entire Record Which Includes, But Is Not Necessarily Limited To All Listed Below (or check separately):

- | | | |
|--|--|--|
| <input type="checkbox"/> History & Physical Exam | <input type="checkbox"/> Surgical Reports | <input type="checkbox"/> Laboratory Results |
| <input type="checkbox"/> Progress Notes | <input type="checkbox"/> Pathology Reports | <input type="checkbox"/> SRMS Laboratory Reports |
| <input type="checkbox"/> Summary of Care | <input type="checkbox"/> Discharge Summary | <input type="checkbox"/> Ultrasound Reports |
- Sexually Transmitted Disease Results Including Acquired Immunodeficiency Syndrome (AIDS) and/or Human Immunodeficiency Virus (HIV)**
- Behavioral or Mental Health Services and/or Treatment for Alcohol and/or Drug Abuse
- Records From Other Physicians: Names: _____

By signing this request, I release and hold harmless SRMS and all employees for all liability, including negligence, that may arise from complying with this authorization. SRMS is authorized by Florida law to charge me for duplication costs incurred in connection with the copying my medical records. Since discussion regarding both partners is common in the medical record, if applicable, we request a separate request for record release from your partner.

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This information is being disclosed for continued medical care. I understand that I have the right to revoke this authorization in writing. I understand that the revocation will not apply to information that has already been released by my authorization. I hereby authorize the disclosure of my medical information from Dr. Sweet's practice. Unless otherwise specified below, this authorization will expire six months from the date of signing.

Signature: _____ Date: ____/____/____ Request Expires: ____/____/____

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