



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: (____) ____ - ____

Requesting Medical Records Via Mail or Fax From:

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 The Items Listed Below:**
- | | | |
|--------------------------------------------------|--------------------------------------------|---------------------------------------------------------|
| <input type="checkbox"/> History & Physical Exam | <input type="checkbox"/> Surgical Reports | <input type="checkbox"/> ART/General Laboratory Results |
| <input type="checkbox"/> Progress Notes | <input type="checkbox"/> Pathology Reports | <input type="checkbox"/> X-Rays (Originals or Copies) |
| <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: _____

Please Send My Medical Records To: Specialists In Reproductive Medicine & Surgery, P.A.

Craig R. Sweet, M.D. & Ancillary Medical Staff
12611 World Plaza Lane, Building 53
Fort Myers, Florida 33907
(239) 275-8118
(239) 275-5914 [fax]

*Please DO NOT send this form
directly to Dr. Sweet's Office!*

*We request that all records be available
for review at least two weeks prior
to your scheduled visit.*

The information included with this cover sheet may be privileged, confidential and protected from disclosure as outlined by the Federal HIPAA Privacy Rules 45 CFR. If the reader is not the intended recipient, you are hereby notified that any reading, dissemination, distribution, copying or other use of this material is strictly prohibited. If you receive this information in error, please notify the sender immediately by the contact numbers listed below.

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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