Specialists In Reproductive Medicine & Surgery, P.A.

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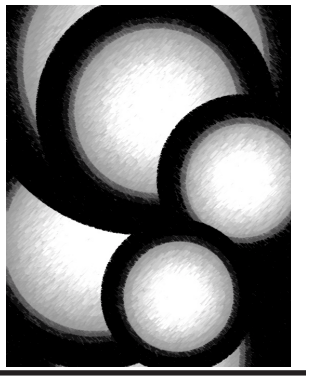
ART Coordinator Supervisor



Requesting Records To Send To SRMS

Patient Identifying & Contact Information (Please print clearly):

Name: _____ Date of Birth: _____/_____/_____
Address: _____ Home Phone: (____) _____-_____
City: _____ Cell Phone: (____) _____-_____
State: _____ Zip: _____ Work Phone: (____) _____-_____
Country _____ E-mail: _____

Requesting Medical Records Sent To SRMS Via ❒Mail or ❒Fax *From*:

Facility/Name: _____
Address: _____ Work Phone: (____) _____-_____
City: _____ Fax: (____) _____-_____
State: _____ Zip: _____ Country Code: _____
Country _____ Contact: _____

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):

❒ History & Physical Exam	❒ Surgical Reports	❒ Outside Laboratory Results
❒ Progress Notes	❒ Pathology Reports	❒ Internal Lab Reports
❒ Summary of Care	❒ Discharge Summary	❒ 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 for other physicians: Names:		

Please Send My Medical Records To:
Specialists In Reproductive Medicine & Surgery, P.A.
12611 World Plaza Lane, Building 53
Fort Myers, Florida 33907, USA
Fax: (239) 275-5914

Please DO NOT send this release to SRMS!

Please DO send this release to your previous medical providor.

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, nation, 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 if being disclosed for continued medical care. I understand that I have the right to revoke this authorization in writing. I understand that revocation will not apply to information that has already be release by my authorization. I hereby authorize the disclosure of my medical information from SRMS. Unless otherwise specified below, this authorization will expire six months from the date of signing.

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