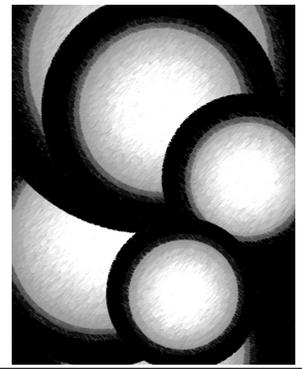


Specialists In Reproductive Medicine & Surgery, P.A.**Craig R. Sweet, M.D.**

Reproductive Endocrinologist, Medical Director

Lorrie Posegay, A.R.N.P.Advanced Registered Nurse Practitioner & Women's Care Specialist
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):

<input type="checkbox"/> History & Physical Exam	<input type="checkbox"/> Surgical Reports	<input type="checkbox"/> Outside Laboratory Results
<input type="checkbox"/> Progress Notes	<input type="checkbox"/> Pathology Reports	<input type="checkbox"/> Internal Lab Reports
<input type="checkbox"/> Summary of Care	<input type="checkbox"/> Discharge Summary	<input type="checkbox"/> Ultrasound Reports
<input type="checkbox"/> Sexually Transmitted Disease Results Including Acquired Immunodeficiency Syndrome (AIDS) and/or Human Immunodeficiency Virus (HIV)		
<input type="checkbox"/> Behavioral or Mental Health Services and/or Treatment for Alcohol and/or Drug Abuse		
<input type="checkbox"/> 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 provider.***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: ____/____/____

12611 World Plaza Lane, Bldg. 53. • Fort Myers, Florida 33907, USA

Phone: (239) 275-8118 • FAX: (001) 239-275-5914

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