

****Please send to referring physician as soon as possible so records will arrive before initial consult.**



Release of Medical Records

Print Name: _____

Address: _____

Date Of Birth: _____

Date of treatment concerned: _____ or All Treatments _____

I hereby authorize:

(Name of Doctor or Hospital to RELEASE Information)

(Address)

to release my complete medical records including all labs and HIV results or as specified above to :

Dr. William Hummel
And Dr. L. Michael Kettel
Of the
San Diego Fertility Center
11515 El Camino Real Suite 100
San Diego, CA 92130

Phone: 858-794-6363 - Fax: 858-794-6360

For possible treatment/care:

I understand I may revoke this consent at anytime except to the extent that action has already been taken on it and that it will expire automatically 90 days from the date below.

I may revoke this consent by notifying that above listed facility I writing.

Signature of Patient: _____ Date: _____

All items must be completed in order to avoid delays in the release of these records.