**Please complete this form and Fax to your previous physician so that we can have your records prior to your visit with our physician.

San Diego Fertility Center

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 92130-2045
Phone: (858) 794-6363
Fax: (858) 794-6360

For possible treatment/care:

I understand I may revoke this consent at any time 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 the above listed facility in writing.

Signature of Patient:_____________________________ Date:_______________________

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