SAN DIEGO Fertility Center

Medical Records Transfer From SDFC

Print Name: _____

Address:_____

Email:_____

Date of Birth:_____

Date of Treatment Concerned: _____ or All Treatments: _____

- ☐ Please email my records to me (I understand that with this option my records cannot be sent via secure connection)
- ☐ Please mail my records to me (enter address above)
- ☐ Please mail my records to my doctor (enter your doctor's address below)
- ☐ Please fax my records to: _____

I hereby authorize:

Dr. L. Michael Kettel, Dr. Susanna Park, Dr. Sandy Chuan, Dr. Brooke Friedman, Dr. Said Daneshmand

11425 El Camino Real
San Diego, CA 92130
Phone: (858) 794-6363 Fax: (858) 794-6360

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

_____
(name of doctor or hospital to release information)

_____
(address)

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 ny notifying the above facility in writing. I understand that once San Diego Fertility Center discloses health information, the person or organization that recieves it may re-disclose it at which time it may no longer be protected under privacy laws.

Signature of Patient: _____ Date:_____

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