REQUEST FOR RELEASE
OF
MEDICAL RECORDS

(Please fill out and fax to your physician upon receipt of this release form)

TO: ____

Physician's Name

____

Address

____

City State Zip

____

Fax #

I hereby request that my medical records be released ***to:***

The Texas Center for Reproductive Health

BAYLOR MEDICAL PLAZA - 3600 GASTON AVE.
BARNETT TOWER, SUITE 504
DALLAS, TEXAS 75246
(214) 821-2274
(214) 821-2373 FAX

Patient's Signature: ____________________________ Print Name: ____________________________ Date: ________

Husband's Signature: ____________________________ Print Name: ____________________________ Date: ________

(Husband's signature is required if you are requesting male factor test results, such as Semen Analysis)