Request to Transfer Medical Records

Please type or print legibly in blue or black ink

Send this request to your physician

To:_____

(Name of the physician or medical group)

I, the undersigned patient, request a copy of my medical records:

Name:_____

Address:

_____

_____

_____

Date of Birth: _____ Social Security Number: _____

Patient ID#(if applicable): _____

Daytime phone number: _____

Evening phone number: _____

Release the requested information to:

Zouves Fertility Center
Attn: Medical Records
1241 E. Hillsdale Blvd., Suite 100
Foster City, CA 94404

Please process this request within 15 calendar days, as provided by law.

This authorization shall be valid for ninety (90) days from the date of my signature below.

A copy of this authorization form shall be deemed as valid as an original.

I hereby authorize you to furnish the medical information requested to **Zouves Fertility Center.**

_____ Date:_____

Patient Signature

_____ Date:_____

Spouse's Signature