Medical Release Form

Patient authorization for copy and release of medical records to Reproductive Care of Indiana

I, _____

(Name of Patient)

_____

(Address of Patient)

_____

(Date of Birth) (SS #)

Hereby authorize Henry Fertility to **obtain copies of my health information from:**

_____

(Name and complete address of healthcare provider)

_____

(Phone and Fax Number)

Portion of protected health information record requested:

_____ Complete medical record

_____ Partial medical records- specific records requested include:

_____

Please forward medical records to:

Michael A. Henry, MD
Henry Fertility
201 Pennsylvania Parkway, Suite 325
Indianapolis, IN 46280
317-817-1800
317-817-1810 FAX

Patient Signature: Date: _____

4/16