



**Request for Medical Records &
Permission for Release of Information**

(Please send this form to all clinics/physicians from previous pregnancies)

Records Requested To: Dr. _____

Address: _____

Phone: _____ Fax: _____

(Last Name) (MI) (First Name) (Maiden Name)

(Street Address) (City) (State) (Zip)

(Telephone) (Last name which records can be found; if different) (DOB)

Please send my records to:

An Eggceptional Match, LLC
P.O. Box 1646
Castle Rock, Colorado 80104
720-733-0184

Prefer Faxed Records to ensure efficiency to: 720-733-2433

(Please provide a complete copy of all medical records rather than a summary)

Records of Care from: _____ to _____ to include **anything** that
could have a bearing on my fertility.

_____ Medical Records/Operative Reports

_____ Laboratory Reports

_____ Biopsy Slides

_____ Hysterosalpingogram, X-rays & Reports

_____ Prenatal Records

_____ Delivery Records

_____ OTHER (Please Specify) _____

I hereby grant permission for release of these records

(Printed Name)

(Date)

(Signature)

(Witness)

(Date)

Appointment Date: _____

Please provide a copy of this form with patient's records