



# Nevada Center for Reproductive

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## Authorization to Release Medical Records

Patient Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ SS# \_\_\_\_\_

FROM: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

TO: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

I hereby authorize and request the release of the following information:

\_\_\_\_\_ All Medical Records

\_\_\_\_\_ Medical record information for visit date of \_\_\_\_\_ to \_\_\_\_\_.

\_\_\_\_\_ Progress Notes

\_\_\_\_\_ Lab reports

\_\_\_\_\_ Hospital and/or Operative reports

\_\_\_\_\_ Other: \_\_\_\_\_.

I understand that my records may contain information regarding the diagnosis or treatment of HIV (AIDS virus), other sexually transmitted diseases, drug and/or alcohol abuse, mental illness or psychiatric treatment, and infertility treatment. I give authorization for these records to be released.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Signature(partner): \_\_\_\_\_ Date: \_\_\_\_\_