Medical Release Form

Physician Request authorization for copy and release of medical records to Henry Fertility *DBA Reproductive Care of Indiana*

I, _____

(Name of Patient)

_____

(Address of Patient)

_____

(Date of Birth) (SS #)

Hereby authorize Reproductive Care of Indiana 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 *DBA Reproductive Care of Indiana*
201 Pennsylvania Parkway, Suite 325
Indianapolis, IN 46280
317-817-1800
317-817-1810 FAX

Physician Signature: Date: _____

4/16