SHERMAN J. SILBER, M.D.
INFERTILITY CENTER OF ST. LOUIS

St. Luke's Hospital Medical Building
224 S. Woods Mill Road, Suite 730
Saint Louis, Missouri USA 63017
(314) 576-1400 • Fax: (314) 576-1442

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS/INFORMATION

I, _____ (DOB: _____) (SSN: _____),

hereby authorize the **physician/medical office indicated below** to release copies of my medical/ treatment records:

Physician Name:_____

Street Address _____

City/State/Zip _____

Telephone: _____ Fax: _____

[ ] Operative Reports
[ ] History & Physical Reports
[ ] Laboratory Results
[ ] Ultrasound Reports
[ ] Pathology Reports
[ ] Other: _____

[ ] IVF Summary Sheets
[ ] Female Summary Sheet
[ ] Male Summary Sheet
[ ] Office Visit Notes
[ ] HIV, Hepatitis, STD Results

I authorize all of the information specifically indicated above as of the following dates of treatment _____ (begin date) through _____ (end date) to be released to the following physician/medical office:

Sherman J. Silber, M.D.
Infertility Center of St. Louis
224 S. Woods Mill Road, Suite 730
St. Louis, MO 63017
(314) 576-1400 (phone)
(314) 576-1405 (fax)

I understand that neither Sherman J. Silber, M.D., nor the Infertility Center of St. Louis, can force me to sign this authorization. I further understand that I may revoke this authorization at any time. The date of expiration for this authorization is as follows: _____. If no expiration date is given, this authorization will expire one year from the date the authorization is signed. I understand that I may request a copy of this signed authorization.

_____ _____

Signature of Patient Date