PCRM Pacific Centre for Reproductive Medicine

To: ________________________________

Fax: ________________________________

RE: ____
(First Name) (Middle Name) (Surname)

DOB: ____
(Day) (Month) (Year)

AHCIP: ______________________________

The above named patient has come under my care and I would be most grateful if you would forward to me, at your earliest convenience, any medical records and/or reports that are in your possession. Thank you for your time.

Sincerely,

Dr. Caitlin Dunne Dr. Jon Havelock Dr. Robert Hemmings Dr. Jeff Roberts
Dr. Ken Seethram Dr. David Smithson

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

Please release the following information:

- ☐ All Medical records
- ☐ Art Cycle Results
- ☐ Consultation Letters
- ☐ History & Physical exam
- ☐ Hysterosalpingogram
- ☐ Semen Analysis
- ☐ Laparoscopy Reports
- ☐ Blood Group
- ☐ Day 3 FSH
- ☐ Rubella Titre
- ☐ SHG
- ☐ Other Operative Reports

I hereby authorize ________________________ to release any medical records of mine in their possession to the above named Doctor(s).

SIGNATURE OF PATIENT: ____

WITNESS: ____

DATE: ____

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