Medical Record Release Form

You need your records ASAP!!

Please follow the instructions below carefully and completely!

Records are mailed within ten (10) business days from the date we receive this completed request form.
The first copy of a patient's medical record is released free of charge. *A fee of 25 cents per page, payable in advance, is charged for additional copies.
Questions? Please contact the Medical Records Department. Phone (781) 674-1202 • Fax (781) 674-1520

NOTE: IVF New England cannot release records sent to our practice from another doctor's office.

Date _____ Patient Name _____ Patient Signature_____

Date of Birth _____/_____/_____ Social Security # _____
MM DD YYYY

Partner/Spouse Name _____ Signature _____

Date of Birth _____/_____/_____ Social Security # _____
MM DD YYYY

Where shall we send your first medical record copy for which there is no fee? CHECK ONE BOX BELOW

WE RECOMMEND that you have your medical records sent to your address and that you make any additional copies as needed for your other physicians.

☐ **To my address below** **OR** ☐ **To my physician's office below**

Patient Address _____
City _____
State _____ Zip Code _____
Reason for Request _____
_____

Physician Name _____
Address _____
City _____
State _____ Zip Code _____
Fax # _____

Check box(es) below to indicate the records you are requesting.

☐ All Records* **(ATTENTION!)**
☐ Ultrasound ☐ Semen Analysis ☐ Progress Notes
☐ PGD Results
☐ Other (specify) _____
☐ Patient infectious disease testing
☐ Partner/spouse infectious disease testing
☐ Patient genetic testing
☐ Partner/spouse genetic testing

Due to Federal healthcare privacy regulations, infectious disease and genetic test results must be specifically requested and are not included in "All Records".

Please check necessary boxes.

IVF New England
Helping people become parents®

One Forbes Road, Lexington, MA 02421
Medical Records Department (781) 674-1202
Fax (781) 674-1520
Form available online at
www.IVFNE.com (Patient Resources)