

Southern California Center for Reproductive Medicine

RECORDS RELEASE REQUEST

Date: _____

To: _____

Address: _____

**Send Original
To Your
Physician**

I hereby authorize you to release to: Robert E. Anderson, M.D. N. Edward Dourron, M.D.

Please send to: 361 Hospital Road, #333
Newport Beach, CA 92663
(949) 642-8727
(949) 642-5413 FAX

26671 Aliso Creek Rd, #206
Aliso Viejo, CA 92656
(949) 831-8929
(949) 831-9006 FAX

Records to be Included: _____

Records to be Excluded: _____

Expiration Date of Authorization

This authorization is effective through ____ / ____ / ____ unless revoked or terminated by the patient or the patient's personal representative.

Potential for Re-disclosure

Information that is disclosed under authorization may be disclosed again by the person or organization to which it is sent. The privacy of this information may not be protected under the federal privacy regulations.

Name of Patient (Print or type)

DOB

SS#

Signature of Patient

Date

Signature of Patient Representative

Relationship of Patient Representative to Patient