Fertility Partnership 5401 Veterans Memorial Parkway, Suite 201. St. Peters, MO 63376

Phone: 636.441.7770 Fax: 636.441.7775

MEDICAL RECORDS RELEASE FORM

I do hereby consent and authorize to release copies of all my medical records, including ultrasounds, blood draws, surgeries, etc. on.

Patient first & last name: (Please Print) _____

Date of Birth: _____/_____/_____ Your phone number: _____

RECORDS REQUESTED FROM:

Physician's Name: _____

Physicians Phone: _____

Physician's Fax: _____

RECORDS TO BE FAXED TO:

Dr. David E. Simckes
Fertility Partnership
5401 Veterans Memorial Parkway, Ste. 201
St. Peters, MO 63376
P: 636.441.7770 F: 636.441.7775

_____ _____/_____/_____

Signature of patient or legal guardian Date