Laurel Fertility Care
GROWING DREAMS TOGETHER

Consent for Medical Information Release

There are times we are asked to give family members or others information on test results, especially if you will not be available to receive them. If you would like for us to give out information regarding your treatment and/or test results to your family or friends, please fill in their name and their relationship to you. Please designate which type of information each person may receive by checking the items we may release and any item we should not disclose. Make your own notes if necessary for clarification.

Type of Information to Release:

All Information: Any and All information we have in our file related to you which may include billing information, appointments, treatment, test results, etc. and information on sexually transmitted disease; HIV/AIDS, birth control, pregnancy and mental health information

Appointment Only: Only information related to appointment dates and times.

STD's/HIV: Information related to sexually transmitted disease including HIV, AIDS, HPV, dysplasia, abnormal paps, herpes, GC, Chlamydia, syphilis, vaginitis, Trichomonas, etc.

Preg/Ab: Information related to pregnancy and abortion.

BC: Information related to preventing pregnancy including birth control pills, diaphragms, condoms, IUD's, etc.

Relationship	Name	Type of Information to release
Spouse/Partner		
Mother		
Father		

This consent to release information will remain in effect until revoked in writing.

_____ Date: _____ _____

Patient Printed Name **Laurel Fertility Care Staff Witness**

_____ Date: _____ _____

Signature Patient **Laurel Fertility Care Staff Signature**