Sy Q Le, M.D.
Board Certified in Reproductive Endocrinology & Infertility

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AUTHORIZATION FOR DISCLOSURE OF CONFIDENTIAL INFORMATION

Patient's Name: ____ Chart #: ___________

Address: ____

Date of Birth: ___________________________________

I hereby authorize and request:

Doctor's Name:____

Address: ____

Phone: ________________________________ Fax: ___________________________________

To release the following information to:

IVFMD, P.A.
7501 LAS COLINAS BLVD., SUITE 200A
IRVING, TX 75063

- Check All That May be Released:

  Infertility notes & relevant studies only

  Other, please specify: ____

- Purpose of Disclosure

  Infertility evaluation

  Other: ____

This authorization shall be valid for 120 days from the date of signature. The patient can revoke this authorization in writing any time prior to the expiration date.

Patient's Signature: __________________________________ Date: ______________________

Witness: ____