WEST COAST FERTILITY CENTERS

11160 Warner Ave Ste 411, Fountain Valley, CA 92708
Phone: (714) 513-1399 Fax: (714) 513-1393

301 W Bastanchury Road, Suite 175, Fullerton, CA 92835
Phone: (714) 446-1234 Fax: (714) 446-9163

AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient's Name: ______________________ SSN: ______________

Partner's Name: ______________________ SSN: ______________

I request & authorize Name: ______________________________

Address: ______________________________

Phone: ______________ Fax: ______________

to release healthcare information of the patient named above to:

Name: ***West Coast Fertility Centers***

Address: ***11160 Warner Avenue, Suite 411, Fountain Valley, CA 92708***

Phone: ***(714) 513 - 1399*** Fax: ***(714) 513-1393***

This request and authorization applies to:

☐ Healthcare information relating to the following treatment, condition, or dates: ______________

☐ All healthcare information

Definition: Sexually Transmitted Disease (STD) as defined by law, RCW 70.24 et seq., includes herpes, herpes simplex, human papilloma virus, wart, genital wart, condyloma, Chlamydia, non-specific urethritis, syphilis, VDRL, chancroid, lymphogranuloma venereuem, HIV (Human Immunodeficiency Virus), AIDS (Acquired Immunodeficiency Syndrome), and gonorrhea

☐ YES ☐ NO I authorize the release of my STD results, HIV/AIDS testing, whether negative or positive, to the person(s) listed above. I understand that the person(s) listed above will be notified that I must give specific written permission before disclosure of these test results to anyone.

☐ YES ☐ NO I authorize the release of any records regarding drug, alcohol, or mental health treatment to the person(s) listed above

Patient's Signature: ______________________ **Date:** ______________

Partner's Signature: ______________________ **Date:** ______________

Internal Use Only

Date	Sent to (Fax Number)	Sent by: (Initials)