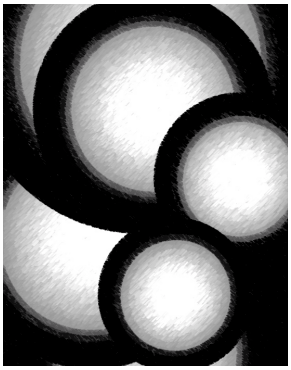

Specialists In Reproductive Medicine & Surgery, P.A.

Embryo Donation International

Craig R. Sweet, M.D.
Reproductive Endocrinologist, Medical Director & Laboratory Director

Lorrie Posegay, A.R.N.P.
Advanced Registered Nurse Practitioner & Women's Care Specialist
ART & Embryo Donation Coordinator Supervisor

Patient Identifying & Contact Information (Please print clearly):

Name: _____ Date of Birth: _____/_____/_____
Address: _____ Home Phone: (____) _____-_____
City: _____ Cell Phone: (____) _____-_____
State: _____ Zip: _____ Work Phone: (____) _____-_____
Country _____ E-mail: _____

Please ❒Mail or ❒Fax My SRMS/EDI Records TO (Please print clearly):

Facility/Name: _____
Address: _____ Work Phone: (____) _____-_____
City: _____ Fax: (____) _____-_____
State: _____ Zip: _____ Country Code: _____
Country _____ Contact: _____

Types of Medical Records To Be Sent (Check Those That Apply):

❒Entire Record Which Includes, But Is Not Necessarily Limited To all Listed Below (or check separately):

❒History & Physical Exam	❒Surgical Reports	❒Outside Laboratory Results
❒Progress Notes	❒Pathology Reports	❒SRMS/EDI Lab Reports
❒Summary of Care	❒Discharge Summary	❒Ultrasound Reports
❒Sexually Transmitted Disease Results Including Acquired Immunodeficiency Syndrome (AIDS) and/or Human Immunodeficiency Virus (HIV)		
❒Behavioral or Mental Health Services and/or Treatment for Alcohol and/or Drug Abuse		
❒Records for other physicians: Names: _____		

By signing this request, I release and hold harmless SRMS-EDI and all employees for all liability, including negligence, that may arise from complying with this authorization. SRMS-EDI is authorized by Florida law to charge me for duplication costs incurred in connection with the copying my medical records. Since discussion regarding both partners is common in the medical record, if applicable, we request a separate request for record release from you partner.

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This information if being disclosed for continued medical care. I understand that I have the right to revoke this authorization in writing. I understand that revocation will not apply to information that has already be release by my authorization. I hereby authorize the disclosure of my medical information from SRMS-EDI. Unless otherwise specified below, this authorization will expire six months from the date of signing.

Signature: _____ Date: _____/____/____ Request Expires: _____/____/____

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