AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Date: _____

I/ We request and authorise _____
(Doctor's and/or Clinic's name)

to release my/our healthcare information to Dr Ashley Fong on an urgent basis.

Kindly fax (**02 8754 3002**) or email (**info@myfertilitycare.com.au**) the following:

Information Required / Requested:

- ☐ Medical imaging
- ☐ Pathology (all blood tests, semen analysis)
- ☐ IVF treatment cycles including medications, dose of FSH, number of days of stimulation, peak estradiol and cycle outcome (eggs retrieved, fertilization & embryo development, pregnancy result)
- ☐ Correspondence letters
- ☐ Other: _____

	First name	Surname	Date of birth	Signature
Patient 1				
Patient 2				