Brian D. Barnett, M.D.
Lowell T. Ku, M.D.
Dara L. Havemann, M.D.

This form can be used for you to send to your OB/GYN or previous treating physician to request your medical records.

Medical Records Release Authorization

Attention:
Doctor: _____

Address: _____

Fax: _____

I hereby authorize and request you to release to:

☐ **Frisco Fertility Center**
2840 Legacy Drive, Suite 100
Frisco, TX 75034
Phone: (214) 297-0020
Fax: (214) 297-0025

☐ **McKinney Fertility Center**
5301 W. University Drive
McKinney, TX 75071
Phone: (469) 219-8210
Fax: (469)-219-8201

Please forward my complete medical history records in your possession, concerning my illness and/or treatment during the period from_____to_____. My appointment is on_____ (date).

Records to include:

- **Any infertility testing or treatment**
- **Embryology reports (if patient has previously undergone IVF)**
- **Records related to pregnancy losses**
- **Any current (within one year)infectious disease screening**
- **Most recent PAP smear results**
- **Any genetic testing**

Name: _____ **DOB:**_____

Address: _____

Signature: _____

Date: _____