PATIENT NAME_____

PATIENT ADDRESS_____

CITY, STATE, ZIP CODE_____

DOB_____

Phone_____

RE: Release of medical records for Patient: _____

I authorize _____

To release all medical records related to my treatment rendered by you from _____

Through _____. This information will be used to further assist in my medical care and

Should be mailed or faxed to:

Tamer Yalcinkaya, MD
Carolinas Fertility Institute
3821 Forrestgate Drive
Winston Salem, NC 27103
Phone (336) 448-9100
Fax (336) 778-7995

PATIENT SIGNATURE _____

DATE OF REQUEST_____