Fertility & Genetics

Mick Abaé, M.D., F.A.C.O.G.

Please request your medical records 10-14 days in advance for proceeding.
Copying Fee: $1 per page and $0.25 for additional pages.

Medical Record Requisition Form

Patients Name: _____
(Please Print) (Last) (First) (Middle)

SSN: _____/_____/_____ DOB: _____/_____/_____

Date Requested: _____ Date records needed: _____

I authorize the release of all of my medical records including the results of infectious disease lab testing such as HIV and Hepatitis to be released to:

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Patients' Signature: _____ Date: _____

For Office Use Only

Authorized By M.D: _____ Date: _____

Processed By: _____ Date: _____

Number of pages: _____ Payment: $_____ Date of Payment: _____

Date Records Released: _____

D.O.S: From: _____- Through: _____

Fax number released to: ( ) _____ Dr. _____

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