

Hello,

Thank you for reaching out. We have received your request for the release of your medical records. To process your request, please complete and return the following:

1. Authorization to Release medical records Consent Forms

Attached are the consent forms required for the release of records. Please complete one form for each individual whose records are being requested (e.g., one for yourself and one for your partner, if applicable).

2. Two Pieces of Valid Government-Issued Photo Identification

Please provide two pieces of valid government-issued photo ID for each individual, whose records are being requested.

3. Administrative Fee

A fee of \$70 applies for the release of full medical files for a couple or a single patient. If you prefer to make payment over the phone, please call at: 905-896-7100.

Payment may be made via E-transfer to **payment@newlifefertility.com**.

Please provide the following details when sending an E-transfer:

Date:

Name:

Phone number:

Reference number

Attn to: Release record

Once all required documents and payment have been received and confirmed, we will proceed with your request. **Processing time may take up to 15 business days.**

The records will be sent to the email address on file unless otherwise specified on the consent forms.

Note: We no longer release **full medical records** directly to other clinics or physicians.

If you have any questions about the process of record release, please feel free to contact NewLife Fertility Centre at: hello@newlifefertility.com

Dr. _____



4250 Sherwoodtowne Blvd.
Mississauga, ON L4Z 2G6
Tel: 905-896-7100
Fax: 1-888-248-1241

Patient Demographic Label

AUTHORIZATION TO DISCLOSE PERSONAL HEALTH INFORMATION

Date: _____

I _____

hereby authorize _____ to disclose my personal
health information to _____.

I am subjected to a fee of \$70 CAD for the release of my information and I acknowledge that it may take up to 14 business days to fulfill this request.

I consent for the following information to be disclosed (please check all that applies):

- ☐ Cycle Monitoring Notes
- ☐ Blood Report(s)
- ☐ Semen Analysis Report(s)
- ☐ OB Reports (Blood and Ultrasounds)
- ☐ Full Records

Please select the method of delivery you would like your information to be released:

- ☐ Email: _____
- ☐ Faxed: _____
- ☐ Hard Copy

Patient/Client Full Name (Printed)

Witness Full Name (Printed)

Patient/Client Signature

Witness Signature

Dr. _____



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Witness Signature