



Request for Transfer of Medical Records to Main Line Fertility

ATTN: _____

PHONE: _____
FAX: _____

I hearby authorize the above party to release the medical records listed below:

Patient Name: _____ Date of Birth: _____

Former Name (If Applicable): _____ Phone Number: _____

Partner Name (If Applicable): _____ Date of Birth: _____

_____ Laboratory Results (including HIV and infectious disease results – Patient Initials _____)

_____ Hysterosalpingogram (HSG)

_____ Hysteroscopy

_____ operative notes: _____

_____ pathology reports: _____

_____ X-Ray reports: _____

_____ X-Ray films: _____

_____ Other: _____

Send to:

- Michael J. Glassner, M.D.
- John J. Orris, D.O.
- Deanna Brasile, D.O.
- Benjamin Gocial, M.D.

Located at:

- Main Line Fertility , 825 Old Lancaster Road, Suite 170, Bryn Mawr, PA 19010 Fax (610) 527-9868
- Main Line Fertility, Paoli Pointe, 11 Industrial Boulevard, Suite 100, Paoli, PA 19301 Fax (610) 993-9355
- Main Line Fertility , 915 Old Fern Hill Road, Building B, Suite 101, West Chester, PA 19380 Fax (610) 840-0062
- Main Line Fertility, 932 Pine Street, Philadelphia, PA 19107 Fax (215) 454-6454

Thank you,

Patient Signature

Date

Partner Signature

Date