Mount Sinai Fertility
Sinai Health System

Mount Sinai Fertility
250 Dundas St W., Suite 700
Toronto, ON M5T 2Z5
Tel: 416-586-4748
Fax: 416-586-4686

Patient Identification	Partner Identification

REQUEST/RELEASE FOR MEDICAL RECORDS

I/We hereby authorize the release of all my records and test results, including HIV test results, in your possession regarding my care/treatment for the period indicated:

□ All available records □ Past 12 months □ From _____ to _____

□ Please specifically include the following items:

1. _____
2. _____
3. _____

□ TO □ FROM

Mount Sinai Fertility
250 Dundas Street West, Suite 700
Toronto, ON M5T 2Z5

□ TO □ FROM

Name/Medical Facility:
Address:
Phone Number (including area code):
Fax Number (including area code):

I/We release you, your physicians, and employees from liability for following this authorization and request. I/We understand that it may take up to 15 business days for completion of this transaction.

Patient Name:	DOB: yyyy/mm/dd	Date:	Patient Signature:
Partner Name:	DOB: yyyy/mm/dd	Date:	Patient Signature: