



REQUEST FOR RELEASE OF MEDICAL RECORDS

TO: _____

TELEPHONE: _____ FAX: _____

I HEREBY REQUEST THAT MY COMPLETE MEDICAL RECORDS BE RELEASED TO:

OC FERTILITY
Sharon E. Moayeri, M.D.
1401 Avocado Avenue, Suite 403
Newport Beach, CA 92660
(949)706-2229 fax (949)706-8490

Patient Signature

Date

PRINT Patient Name

Social Security Number

Date of Birth

*****If records are under 20 pages ok to fax. If over 20 pages please mail directly to our office*****