Fertility & Women's
HEALTH CENTER OF LOUISIANA
Helping couples build families.

Emergency Contact:

Name	Relationship to Pt.	Phone Number
_____	_____	_____

Were you referred to this office? **Y** **N**

If so, by whom? _____

I authorize the release of all medical records to the referring physician and/or to my insurance company should it be requested. I permit a copy of this authorization to be used in lieu of the original.

Date	Signature
_____	_____

❖ I, _____ (the patient), do hereby give my permission to release medical information to:

1. _____ _____ _____ **2.** _____ _____ _____

Name of Person Relationship Initials of pt Name of Person Relationship Initials of pt

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