ASSOCIATES IN women's health

Fertility Treatment Release

Patient Name: _____ Date of birth: _____

Partner Information:

Spouse/Partner Name:_____ Date of Birth:_____ SS#: _____

Home Address: _____

Home Phone #: _____ Cell Phone #: _____ Work Phone #:_____

Insurance Company: _____

Subscriber Name: _____ SS#: _____

ID #: _____ Group #:_____

I authorize the release of all medical information and test results relating to fertility management to my partner/spouse. I understand that Associates in Women's Health cannot order nor be responsible for my spouse/partner's tests without this release.

It has been recommended that my partner/spouse should have sexually transmitted disease testing including: Chlamydia, Gonorrhea, Syphilis, Hepatitis B, Hepatitis C, and HIV. This can be done at Associates in Women's Health or through my partner/spouse's primary care doctor. We have indicated our preference below.

☐ Declines STD testing ☐ Desires STD testing at AWH

☐ Desires testing at primary care physician

_____ _____
Patient's Signature Date

_____ _____
Partner/Spouse Signature Date

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