



## 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

Medical Arts Building  
825 Nicollet Mall, Suite 735  
Minneapolis, MN 55402  
FAX: 952-806-9741

Edina Location  
6565 France Ave South, Suite 200  
Edina, MN 55435  
FAX: 952-806-9741

**Centralized Switchboard and Scheduling: 952-806-0011**  
**[www.awhpa.com](http://www.awhpa.com)**