Fertility Specialists of Texas
Jerald Goldstein, M.D.

Date: ______________________

TO: ____
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I hereby grant my permission for release of records relating to my care to the following parties:

Fertility Specialists of Texas
Jerald Goldstein, MD
8230 Walnut Hill Lane #300
Dallas, Texas 75231
T: 214-750-5500 Fax 214-750-5540

The purpose of the release for information is to provide continuity of my care. I specify that this release includes:

( ) Entire Chart
( ) Any infertility treatment records, labs, last pap smear, any operative reports
( ) Those listed below:

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A facsimile copy of this form is as valid as the original.

______________________	____________________	________________
Patient Signature	Date	SSN
______________________	____________________	________________
Patient Printed Name	Date of Birth	Former Name(s)