REQUEST FOR MEDICAL RECORDS

Please furnish a complete copy of my medical records to:

The Fertility Institutes
Jeffrey Steinberg
16030 Ventura Blvd., Suite 404
Encino, CA 91436

Patient Name: ____

Patient Signature: ____

Date of Birth: ____

Social Security Number: ____________________________________

Date: ____

The Fertility Institutes • Los Angeles • New York • Mexico • www.fertility-docs.com • TZFertility@aol.com