Ontario Network of Experts in Fertility
life through knowledge

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RELEASE | Direction for Release of Medical Records

I, the undersigned, do hereby authorize One Fertility to release any and all of my medical records (including all prior medical history) and/or medical information to:

Name: _____

(please print clearly)

Address: _____

_____

_____

Patient Name: _____ HIN: _____

(please print clearly)

Patient Signature: _____ Date: _____

Witness: _____ Date: _____