Consent for Release of Information to Olive Fertility Centre

OLIVE
fertility centre

Date: _____

Doctor/Clinic:

Name: _____

Address: _____

Phone/Fax: _____

This will constitute your authorization to release copies of the following records to Olive Fertility Centre at:

555 W 12th Ave East Tower, 3rd Floor, Vancouver BC V5Z 3X7
Phone: 604-559-9950 • Fax: 604-559-9951

Please release the following information:

- ☐ History and physical exam
- ☐ Consultation letters
- ☐ Hysterosalpingogram
- ☐ Laparoscopy report(s)
- ☐ Other operative reports
- ☐ Results from each ART cycle (including Stimulation Sheet and Embryo quality)
- ☐ Semen analysis
- ☐ Blood group
- ☐ Rubella titre
- ☐ Day 3 FSH
- ☐ All

Comments:

The patient realizes that this is a service not covered by MSP and that they are responsible for any charges that may be incurred for this service.

_____	_____
Signature	Partner's Signature
_____	_____
Name	Partner's Name
_____	_____
Date	Date

Partner's surname, if different from above: _____