



**Laurel**  
**Fertility Care**

A Professional Medical Corporation

*Growing dreams together*

## CONSENT FOR RELEASE OF MEDICAL INFORMATION

Date: \_\_\_\_\_

I hereby authorize Dr. \_\_\_\_\_ to release to Drs. Collin Smikle and Lee Kao, M.D. my medical records including history and physical, laboratory reports, x-rays, and any other material regarding the medical consultations and treatment(s) which I have received.

Signature: \_\_\_\_\_

Name: (print) \_\_\_\_\_

Birthdate: \_\_\_\_\_

Social Security Number: \_\_\_\_\_

Please send requested information to:

Collin Smikle, M.D. or Lee Kao, MD, PhD  
1700 California Street, Suite 570  
San Francisco, CA 94109  
FAX: 415-673-8796

**Note: Give this completed form to your doctor to send your medical records to us.**