



CONNECTICUT FERTILITY ASSOCIATES

DATE: _____

I, _____

(D.O.B. _____; S.S. # _____ - _____ - _____

HEREBY AUTHORIZE :

TO RELEASE MY MEDICAL RECORDS TO:

CONNECTICUT FERTILITY ASSOCIATES

148 EAST AVENUE
NORWALK, CT 06851
PHONE: (203) 855-1200
FAX: (203) 866-3668

4920 MAIN STREET
BRIDGEPORT, CT 06606
PHONE: (203) 373-1200
FAX: 203-365-6516

339 BOSTON POST ROAD
ORANGE, CT 06477
PHONE: (203- 799-1200
FAX: 795-3848

SIGNATURE