

**Center for Reproductive Medicine
Three Mobile Infirmery Circle
Suite 213
Mobile, Alabama 36607
(251)438-4200**

I, _____, give my permission to release any and all of my test results to my spouse / partner and/or parent listed below.

Spouse/Partner _____

Parent _____

Other _____

I also give my permission to be contacted or for a message to be left in regards to any account balance, test results and/or any treatment and care by Dr. Koulianos and / or Dr. Inge by circling *yes* or *no*:

Method of Contact:

Phone Number

Home Phone	Yes	or	No	#	_____
Cellular Phone	Yes	or	No	#	_____
Work Phone	Yes	or	No	#	_____
Spouse / Partner home and/or work	Yes	or	No	#	_____
Fax	Yes	or	No	#	_____
E-Mail	Yes	or	No		_____

Patient signature

date

Witness signature