

**Fertility Specialists of Dallas, P.A.**  
**Jerald Goldstein, M.D.**

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

TO: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

I hereby grant my permission for release of records relating to my care to the following parties:

**Fertility Specialists of Dallas, PA**  
**Jerald Goldstein, MD**  
**8315 Walnut Hill Lane, Ste. 225**  
**Dallas, Texas 75231**  
**214-750-5500 Fax 214-750-5540**

The purpose of the release for information is to provide continuity of my care for processing insurance claims or to meet another specific desire of mine. I specify that this release includes:

- Entire Chart
- Any infertility treatment records, labs, last pap smear, any operative reports
- Those listed below:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

A facsimile copy of this form is as valid as the original.

\_\_\_\_\_  
Patient Signature                      Date                      SSN

\_\_\_\_\_  
Patient Printed Name                      Date of Birth                      Former Name(s)