DURANGO REPRODUCTIVE MEDICINE
RECORD RELEASE

To: _____

Street Address: _____

City, State, Zip: _____

Phone/Fax#: _____

I hereby authorize release of my complete medical records to be sent to:

Durango Reproductive Medicine
1199 Main Avenue, Suite 218
Durango, Colorado 81301
970.382.9505 / Fax 970.382.9558

_____
Signature of Patient

_____
Printed Name

_____
Date of Birth

_____
Date of Request

Questions may be directed to 970.382.9505