Consent To Release Information

Infertility and Reproductive Medicine Center
Washington University Physicians and Barnes-Jewish Hospital

Patient

I, ____ , hereby authorize the Infertility and Reproductive Medicine Center at Washington University School of Medicine and Barnes-Jewish Hospital staff to discuss my medical treatment (including test results) as follows (*check all that apply*):

- ☐ Leave message at home
- ☐ Leave message at work
- ☐ Leave message on cell phone # ______________________
- ☐ Discuss medical treatment with my spouse/significant other
- ☐ Discuss medical treatment with my parent
- ☐ Discuss medical treatment with: ____

Spouse/Significant Other

I, ____ , hereby authorize the Infertility and Reproductive Medicine Center at Washington University School of Medicine and Barnes-Jewish Hospital staff to discuss my medical treatment (including test results) as follows (*check all that apply*):

- ☐ Leave message at home
- ☐ Leave message at work
- ☐ Leave message on cell phone # ______________________
- ☐ Discuss medical treatment with my spouse/significant other
- ☐ Discuss medical treatment with my parent
- ☐ Discuss medical treatment with: ____

I understand that it is my responsibility to inform the office if any of the above directives change.

____ ______________________
Patient Name Date

____ ______________________
Spouse/Significant Other Name Date

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