



MEDICAL RECORDS AND INFORMATION RELEASE

We, _____, give permission to

Name of Physician or Medical Facility

To send copies of our medical records or to respond to requests of information from any agent of Angels of Hope, Inc., NFP, in connection with our application for financial assistance from the *Creating Miracles Grant* program, designed to help financially needy married couples with the monetary burden of fertility assistance.

THE INFORMATION TO BE RELEASED includes, but is not limited to, the following:

Medical Summary	Consultations
Treatment Planning	Pathology Reports
Operative Reports	Clinic/Office Records
Lab Reports	Integrated Assessments
Radiology Reports	Psychological testing/Assessments
Alcohol/Drug Dependency	HIV test results

Patient Signature

Date

Printed Name

Phone Number

Patient Signature

Date

Printed Name

Phone Number

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