

Sharing Agreement



Suite 301
46 S. Glebe Rd.
Arlington, VA 22204

Dear Patient:

Infertility involves treatments with both the male and female partners. Consequently, we ask that you agree to allow us to share medical information with your partner.

We agree to allow information about our medical care contained in our medical records to be shared with our spouse or partner.

_____/_____/_____
Patient's Signature Date

Name (Printed or Typed)

_____/_____/_____
Partner's Signature Date

Name (Printed or Typed)