This form can be used for **you to send to your OB/GYN**
or previous doctor to request your medical records.
Please note: some physicians may require up to one month to process medical records requests.

Records Release Authorization
Attention:

Doctor/Hospital: ____

Address: ____

Fax: (______)________________________

I hereby authorize and request you to release to:

Reproductive Medicine Associates of New Jersey
(Please circle the location of your visit)

140 Allen Road
Basking Ridge NJ 07920
Phone: 908-604-7800

Meridian Center 1
2 Industrial Way West
Suite 204
Eatontown, NJ 07724
Phone: 732-935-1002

25 Rockwood Place
Suite 125
Englewood, NJ 07631
Phone: 201-569-7773

109 Professsional View Drive
Freehold, NJ 07728
Phone: 732-577-6500

731 Alexander Road
Suite 203
Princeton, NJ 08540
Phone: 609-799-5666

767 East Route 70
Building B101
Marlton, NJ 08053
Phone: 856-267-8100

111 Madison Avenue
Suite 100
Morristown, NJ 07960
Phone: 973-971-4600

81 Veronica Avenue
Somerset, NJ 08873
Phone: 732-220-9060

955 S. Springfield Avenue
Building A
Springfield, NJ 07081
Phone: 973-258-4081

475 Prospect Avenue
Suite 101
West Orange, NJ 07052
Phone: 973-325-2229

Fax number for all offices: 973-290-8370 **Email for all offices: PServices@rmanj.com**

The complete history records in your possession, concerning my illness and/or treatment during the period from _________ to____________. My appointment is on __________(date).
Records to include:

- **Any infertility testing or treatment**
- **Embryology reports (if patient has previously undergone IVF)**
- **Any records related to pregnancy or pregnancy loss**
- **Any gynecological radiology reports**
- **Any current (within one year) infectious disease results, for patient or partner**
- **Any genetic testing for patient or partner**
- **Any documentation of medical problems that may affect a pregnancy or an attempt to become pregnant.**

Name____ **Date**_____________

Address: ____________________________________

Signature: ____________________________________