The Source for New Beginnings
RMA
Reproductive Medicine Associates of Southern California
IVIRMA Global

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 Southern California

11500 W Olympic Blvd.
Suite 150, Los Angeles, CA 90064
Phone: 424-293-8841

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: _____