The Source for New Beginnings
RMA
Reproductive Medicine Associates of New Jersey

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)

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

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

Summit Office
Use West Orange
address and phone

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

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

100 Franklin Square Dr.
Suite 200
Somerset, NJ 08873
Phone: 537-0631

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

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: _____