



## AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_

SS# \_\_\_\_\_ Telephone: \_\_\_\_\_

I hereby authorize the physician(s) and facility listed below to release and forward any and all records with particular reference to infertility and/or any gynecological or hormonal problem, by my appointment date on ) \_\_\_\_\_ with  Brad Miller, M.D.  Lynda Wolf, MD.

RMA of Michigan to **RECEIVE** Medical Records **FROM**:

Physician: \_\_\_\_\_

Practice Name: \_\_\_\_\_

Address: \_\_\_\_\_

City, State, Zip Code: \_\_\_\_\_

Phone: \_\_\_\_\_

Fax: \_\_\_\_\_

Please include the following:

Recent Pap smear result

All Lab results

Any other pertinent records related to infertility including notes on IUI or IVF

Hysterosalpingogram (HSG) report

Any operative records and pathology results

Semen Analysis result

Other: \_\_\_\_\_

Send Records to: Reproductive Medicine Associates of Michigan, PLC

Attn: Patient Services

130 Town Center Drive, Suite 106

Troy, MI 48084

Telephone: (248) 619-3100 Fax: (248) 619-9031

This authorization shall become effective immediately unless indicated otherwise or revoked earlier in writing. I understand that this information cannot be further released without my specific written consent.

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date