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