The Source for New Beginnings
RMA Michigan
Reproductive Medicine Associates of Michigan
130 Town Center Dr., Ste. 106 Troy, MI 48084
Phone: (248) 619-3100 Fax; (248) 619-9031

AUTHORIZATION FOR THE RELEASE OF MEDICAL RECORDS

Patient Name: _____
(First) (M.I.) (Last)

Address: _____

SS #: _____ DOB: _____

At the request of the individual, I_____, do hereby authorize Reproductive Medicine Associates of Michigan to release for the time period dating from _____to _____:

__History & Physical
__Consultation Notes
__Operative Reports
__Stim sheets
__Laboratory Reports
__Radiology Reports/HSG/Saline Sono
__Pathology Reports
__ All Records
__ Images on flash drive /HSG/Hysteroscopy (**Additional $30 for images)**

__I DO __I DO NOT **authorize release of information related to AIDS or HIV infection, sexually transmitted diseases, genetic testing, psychiatric care/or psychological assessment and treatment for alcohol and /or drug abuse.**

Information Release to:
(Records can only be mailed or faxed to physician's office, not emailed)

_____
Name of Company/Agent/Facility/Person

_____
Street Address

_____
City, State, Zip Code

_____
Phone Number or Fax Number

_____
Patient Email Address

I understand that you will provide this information within 7 business days from receipt of request, and that I am responsible for any fee for preparing and processing this request. I hereby authorize disclosure of the health information for the above named patient. This authorization is valid for 12 months from the date of signature and I may cancel this request within written notification. I understand that the information used or disclosed may no longer be protected by federal privacy laws. I further understand that medical records provided by another healthcare provider or entity and that once the requested records are in RMA of Michigan's possession; they will not be copied or redistributed. By signing below I represent and warrant that I have authority to sign this document and authorized the use or disclosure of protected health information.

_____ _____/____/_____
Signature (patient or person legally authorized to consent on patient's behalf) **Date**

_____ _____/____/_____
Signature (partner if records are being requested) **Date**

Please provide current telephone number if we need to contact you: _____

***THIS FORM CAN BE EMAILED TO RMAMIRECORDS@RMAMI.COM**