



Reproductive Medicine Associates of New Jersey

**This form can be used for you to send to your OB/GYN  
to request your medical records.**

**Records Release Authorization**

**Attention:**

**Doctor/Hospital:** \_\_\_\_\_

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

**I hereby authorize and request you to release to:**

**Reproductive Medicine Associates of New Jersey**

*(Please circle which location)*

111 Madison Avenue  
Suite 100  
**Morristown, NJ**  
07962  
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

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

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

**Please use fax number 973-290-8370 for all locations**

**The complete history records in your possession, concerning my  
illness and/or treatment during the period from \_\_\_\_\_  
to \_\_\_\_\_.**

**Name** \_\_\_\_\_ **Date** \_\_\_\_\_

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

**Signature:** \_\_\_\_\_