This form is to be used to request your medical records from your previous Urologist.

Please note: some physicians may require up to one month to process medical records requests, please send directly to your prior doctors office .

Records Release Authorization

Attention:_____

Doctor/Hospital: _____

Address: _____

Fax: (_____**)**_____

I hereby authorize and request you to release to:

Reproductive Medicine Associates of New Jersey
140 Allen Road
Basking Ridge NJ 07920
908-604-7800
Fax# 973-290-8370
Email pservices@ivirma.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 should include:

- **Hormonal bloodwork completed in the past year and any genetic testing**
- **Urological operative reports**
- **MD consultation notes**
- **Urological radiology reports**
- **Semen analysis reports**
- **Any documentation of medical problems that may affect the fertility health of the patient**
- **Any previous infertility testing**

Name_____ **DOB:**_____

Address: _____

Signature: _____ Date:_____