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
___ Progress Notes
___ Consultation Notes
___ Operative Reports
___ Stim Sheets
___ Laboratory Reports
___ Radiology Reports/HSG/Saline Sono
___ Pathology Reports
___ Partner Records
___ All Records

__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

____
Fax Number

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: ___________________________