



Authorization for Release of Patient Medical Records

There is a cost to release your medical records. For records over 10 pages, The charge is \$23.04 for electronic copies and \$29.19 for paper copies.

Please complete the authorization form and return it by one of the following methods:

- EMAIL** Scan/photograph the completed form and email to RecordRequest@ivirma.com

- FAX** Fax the completed form to: 215-938-8756

- DROP OFF** the completed form in person at any of our four office locations.

If your partner needs a copy of his or her medical records, he or she must fill out a separate form.

To ensure accurate and timely release of records, please print legibly, in black or dark-colored ink.

Please ensure that all information is complete and accurate. Any errors or missing information may delay the release of your records.

If you require further assistance, please do not hesitate to contact our office. We appreciate your cooperation.

1015 Chestnut Street
8th Floor
Philadelphia, PA 19107
Phone: 215-922-1556
Fax: 215-922-1565

735 Fitzwatertown Road
Suite 2
Willow Grove, PA 19090
Phone: 215-938-1515
Fax: 215-938-8756

930 Town Center Dr.
Suite G-75
Langhorne, PA 19047
Phone: 267-852-0780
Fax: 267-852-0786

625 Clark Avenue
Suite 17B
King of Prussia, PA 19406
Phone: 215-654-1544
Fax: 215-654-1543



Patient Information

Legal Name (Last, First, Middle Initial)		
Date of Birth (MM/DD/YYYY)	Social Security Number	Phone Number
Address		
Please list any other names the patient has been known by:		

Partner Information

Legal Name (Last, First, Middle Initial)	Date of Birth (MM/DD/YYYY)
--	----------------------------

Reason for Request (Select all that apply)

<input type="radio"/> Second Opinion	<input type="radio"/> Moved out of area
<input type="radio"/> Insurance Purposes	<input type="radio"/> Urology Referral
<input type="radio"/> Copy to Primary Care Provider	<input type="radio"/> Other Referral
<input type="radio"/> Copy to Ob/Gyn	<input type="radio"/> Copy for my own use
<input type="radio"/> Other (Please Specify):	<input type="radio"/> Transfer of care to another fertility clinic

Date of Appointment (if applicable):

I hereby authorize Reproductive Medicine Associates of Philadelphia, P.C. to release my Protected Health Information to the following individual(s):

Self (Select One)

<input type="radio"/> Pick Up at Office:	Center City	King of Prussia	Langhorne	Willow Grove
<input type="radio"/> Mail	Address if different from above:			
<input type="radio"/> E-mail				

Medical Practice, Physician, or Third Party

<input type="radio"/> Fax	Name of Practice or Physician:	
	Phone Number	Fax Number



Authorization

I hereby authorize a copy of the following to be released (Select all that apply):

- All healthcare information records (**except for HIV unless authorization is marked**)
- Psychological evaluations
- Only healthcare information pertaining to the following test(s), procedure(s), or dates:
- Notes related to procedures performed at RMA of Philadelphia's Surgical Center.
- Information pertaining to my HIV status, records of care and treatment for HIV/AIDS; records of care and treatment for sexually transmitted or communicable diseases; and records of substance abuse care and treatment.**

I understand that it may take up to 15 business days to complete this request.

I understand that any records from another facility will not be included in this release unless specified.

I understand that any records pertaining to procedures at the RMA of Philadelphia Surgical Center may require a separate request for the full record.

I understand that my records may only be released via electronic mail if I have a consent on file authorizing electronic communication to the specified address.

I understand that my partner must complete his/her own release form in order to receive his/her own records.

I understand that once I have obtained my medical records from Reproductive Medicine Associates of Philadelphia, P.C., the Federal Privacy Law no longer protects them.

I understand that I may revoke this authorization in writing at any time by delivering a written notice to the Medical Records Manager of Reproductive Medicine Associates of Philadelphia, P.C. I also understand that any revocation will not do anything about the disclosure of records that I already asked to be released, or where anything else has been done because of my previous request for release of records.

I understand that information used or disclosed because of this authorization could be subject to re-disclosure by the recipient and, if so, may not be subject to federal and state law protecting its confidentiality.

I understand that the records I am receiving are a copy, and that the original will remain at Reproductive Medicine Associates of Philadelphia, P.C.

I understand that I will be charged for the release of my medical records, at a rate of \$23.04 (electronic) or \$29.19 (paper) if my records exceed ten pages.

I hereby attest that I am the patient, or legal representative thereof, listed above and that the information contained in this form is accurate to the best of my knowledge.

By signing my name, I am attesting that I have read and agree to the terms listed above.

Signature

Date

This release will remain in effect for one full year from the date it was signed, unless revoked by the patient.



Credit Card Authorization

I hereby give my fully-informed consent, and agree to allow **Reproductive Medicine Associates of Philadelphia, P.C.** to charge/debit my card, listed below.

Patient's Information, if not Cardholder	
Legal Name (Last, First, Middle Initial)	Date of Birth (MM/DD/YYYY)
Address	

By signing this credit card authorization, I give Reproductive Medicine Associates of Philadelphia, P.C. permission to charge the credit card listed below for services provided to the patient, listed above.

Credit Card Information	
Card Number	Card Type: <input type="checkbox"/> Visa <input type="checkbox"/> MC <input type="checkbox"/> Discover
Expiration Date	Security Code
Printed Name	Date of Birth (MM/DD/YYYY)
Signature	