rma Philadelphia

## Patient Information

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

## Releasing Provider

| Name of Provider/Office | Phone Number | Fax Number |
|---|---|---|
| | | |

| Address | Specialty of Releasing Provider |
|---|---|
| | ◯ Primary Care ◯ Ob/Gyn ◯ Other: |

## Release To (select one):

| Dr. Jacqueline Gutmann, MD | Dr. Arthur Castelbaum, MD<br>Dr. Jeffrey Thorne, MD | Dr. Martin Freedman, MD<br>Dr. Allison Lange, MD | Dr. William Schlaff, MD |
|---|---|---|---|
| 1015 Chestnut St.<br>8th Floor<br>Philadelphia, PA 19107<br>Phone: 215-922-1556<br>Fax: 215-922-1565 | 1151 Old York Road<br>Abington, Pennsylvania 19001<br>Phone: 215-938-1515<br>Fax: 215-938-8756 | 930 Town Center Dr.<br>Suite G-75<br>Langhorne, PA 19047<br>Phone: 267-852-0780<br>Fax: 267-852-0786 | 625 Clark Avenue<br>Suite 17B<br>King of Prussia, PA 19406<br>Phone: 215-654-1544<br>Fax: 215-654-1543 |

Release via: ◯ Mail ◯ Fax ◯ Patient Pickup

Reason for Request:

## Authorization

I hereby authorize a copy of the following to be released to RMA of Philadelphia/RMA of Central Pennsylvania (Select all that apply):

◯ All healthcare information records

◯ Only healthcare information pertaining to the following test(s), procedure(s), or dates:

◯ **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; records of psychiatric care and treatment; records of substance abuse care and treatment.**

I understand that I may revoke this Authorization at any time by providing my written revocation to any RMA office address listed above. I understand that my revocation will not apply to information already retained, used, or disclosed in response to this Authorization, and that revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.

Unless sooner revoked, the automatic expiration date of this Authorization will be twelve (12) months from the date of signature.

I understand that authorizing the disclosure of this health information is voluntary and you have my consent to release medical records for all dates including all diagnostic tests of any type and reports, history, hospitalization, diagnosis, prognosis, treatment, medication and pharmacy records, correspondence, consults, statement of charges or expenses. Any and all reports of any type or character.

I understand that the information authorized for release may include records which may indicate the presence of a communicable or non-communicable disease.

I understand I do not have to sign this authorization in order to obtain health care benefits (treatment, payment, or enrollment).

Information used or disclosed under this Authorization may be subject to re-disclosure by the recipient and no longer protected by federal privacy regulations.

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

Signature Date