Philadelphia

Authorization for Release of Patient Medical Records

There is a cost to release your medical records. These rates are $0.15 per page + $1.00 processing fee, and the cost of postage if requesting mailed records.

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.
ELECTRONIC	Request to electronically complete the form through DocuSign.

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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

1151 Old York Road
Abington, Pennsylvania 19001
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

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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)

◯ Second Opinion	◯ Moved out of area
◯ Insurance Purposes	◯ Urology Referral
◯ Copy to Primary Care Provider	◯ Other Referral
◯ Copy to Ob/Gyn	◯ Copy for my own use
◯ Other (Please Specify):	◯ 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)

◯ Pick Up at Office: Center City King of Prussia Langhorne Abington

◯ Mail Address if different from above:

◯ E-mail

Medical Practice, Physician, or Third Party

◯ 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 seperate 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 $0.15 per page + $1.00 processing fee, and the cost of postage if requesting mailed records.

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.

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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: Visa MC Discover
Expiration Date	Security Code
Printed Name	Date of Birth (MM/DD/YYYY)
Signature	