Authorization for Release of Pregnancy Discharge 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.

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

1151 Old York Road
Abington, Pennsylvania 19001
Phone: 215-938-
Fax: 215-938-8756 -1515

930 Town Center Drive
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)

Referral Information
Name of Ob/Gyn Practice or Physician:
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 (circle one):	Center City	King of Prussia	Langhorne	Abington
◯ Certified Mail	Address if different from above:			
◯ Fax	Fax Number		◯ E-mail	

Medical Practice, Physician, or Third Party		
◯ Fax	Name of Practice or Physician:	
	Phone Number	Fax Number

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Authorization
I hereby authorize a copy of the following to be released (Select all that apply):
◯ All healthcare information records pertaining to my pregnancy care (**except for HIV unless authorization is marked)**
◯ **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.**
◯ Preimplantation Genetic Diagnosis Report: this report contains information regarding sex of the embryo and specific abnormalities. If you do not wish to receive this information, a copy of this report can be disclosed to a noted recipient.

I understand that it may take 2-3 business days to complete this request.

I understand the practice will charge $25.00 for additional requests after this first request.

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

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 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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