rma Reproductive Medicine Associates

Authorization for Release of Pregnancy Discharge Records.

Your records will be sent directly to your OBGYN within 4 business days of your discharge from RMA. **Please alert us if your appointment is sooner**. After they are released to your OB, a copy can be emailed to you if so indicated on your release form.

We may need to request that you complete an additional form for email consent if we do not already have one on file and you are requesting your records to also be sent to you electronically.

Please ensure that all information is complete and accurate. Any errors or missing information may delay the release of your records. To ensure accurate and timely release of records, please print legibly in black or dark ink.

There is no cost associated with this request.

Pregnancy Images are available to view on our patient portal.
Requests for images outside of the portal are subject to a $25 fee.

If your partner needs a copy of his or her medical records, they must fill out their own copy of this form. Their first copy will be at no charge; any additional requests are subject to a fee.

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

Email Scan/Photograph the completed form and email to RMALV_PatientServices@ivirma.com

Fax Fax the completed form(s) to 973-290-8370

Mail Mail the completed form to:
RMA PA
Attn: Medical Records
1401 North Cedar Crest Blvd
Suite 200
Allentown, PA 18104

Drop Off the completed form in person to any of our office locations.

If you require further assistance, please do not hesitate to contact our office at 610-820-6888.

Authorization for Release of Patient Health Information
Discharge Release Form

Patient Information	
Legal Name	
Date of Birth (MM/DD/YYYY)	Phone

- I understand that the information in my health record may include disclosure of information relating to communicable disease, Acquired Immunodeficiency Syndrome (AIDS), Human Immunodeficiency Virus (HIV), alcohol/drug (substance) abuse or any such related information.
- I understand that this medical records request will be processed within 4 business days of my discharge.
- 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 needs to complete a separate release form in order to receive their own records.
- I understand that any records from another facility will not be included in this release.
- I understand that there is no charge for this request but there will be a fee assessed for any additional requests.

Description of Information to be released:
Pregnancy records including, but not limited to, Laboratory Reports, Genetic Testing, HIV/Infectious Disease Panel, Radiology/Ultrasound Reports, surgical reports and office visit notes.
When applicable these records will also include Pre-Implantation Genetic Testing*
***Please note that this Report will automatically include the sex of your embryo(s)**

Description or purpose for the use and/or disclosure of my medical records: Discharge to OBGYN

Permission to release records to OBGYN:	
Receiving Provider:	Practice Name:
Phone Number:	Fax Number:
Email:	Date of Appointment:

Records Released to Patient (if requested):	
Patient Email Address:	Mailing Address:

1. I understand that I may inspect or obtain a copy of the protected health information described by this authorization.
2. I understand that RMA will not condition treatment upon my providing this authorization for use and disclosure of Protected Health Information and that I MAY REFUSE TO SIGN THIS AUTHORIZATION.
3. I understand that I may revoke this authorization in writing at any time by delivering such written revocation to the Privacy Officer of Reproductive Medicine Associates. I also understand that such revocation will not be effective as to the disclosure of records whose release I have previously authorized, or where other action has been taken in reliance on an authorization I have signed.
4. I understand that information used or disclosed pursuant to this authorization could be subject to re-disclosure by the recipient and, if so, may not be subject to federal or state law protecting its confidentiality.

State law requires an individual to give specific consent for the release of protected health information related to certain disease conditions.
By my signature below, I authorize RMA to release any information that may be in my medical records regarding my HIV status, records of Mental Health care and treatment, records of Substance Abuse care and treatment, and records of Sexually Transmitted Disease care and treatment, if I have so noted above.

Signature:	Date:

This authorization will expire twelve months after it is signed unless otherwise revoked by the patient.