# Authorization for Release of Patient Medical Records

Please complete the attached Release Authorization.

You can return this form by one of the following methods.

| | |
|---|---|
| **Email** | Scan/Photograph the completed form and email to MRecords@ivirma.com |
| **Fax** | Fax the completed form(s) to 973-290-8370 |
| **Mail** | Mail the completed form to:<br>RMANJ<br>Attn: Medical Records<br>140 Allen Road<br>Basking Ridge, NJ 07920 |
| **Drop Off** | the completed form in person to any of our office locations. |
| **Electronic** | Request to electronically complete the form through DocuSign |

Please allow us 10 business days to process all requests for Medical Records.

RMA does not release records from other facilities. You must obtain those records from the original source.

If your partner needs a copy of their medical records, they must fill out their own copy of this form.

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

If you are requesting your records electronically, we may need to request that you complete an additional form for email consent if we do not already have one on file, or if your email address has changed.

Records from any of our mental health professionals will require a separate release form to be completed.

Please note that if you are looking for copies of reports from LabCorp or Quest, you may quickly access those results through the patient portal associated with each lab.
LabCorp: https://patient.labcorp.com/ui
Quest: https://myquest.questdiagnostics.com/web/home

If you require further assistance, please do not hesitate to contact our Medical Records Department at 973-871-2290.

# Authorization for Release of Patient Health Information

| 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 medical records requests will be processed within 10 business days.
- I understand there may be an additional fee for postage if I wish to have my records sent by mail.
- 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 any records from another facility will not be included in this release.
- I understand that a separate release form is needed for records from any mental health consults.

## Description of Information to be released (please check all that apply):

☐ HIV/Infectious Disease Panel ☐ Laboratory Reports ☐ Office Visit Notes ☐ Surgical Reports

☐ Embryology Reports ☐Pre-Implantation Genetic Testing* ☐ Ultrasound/Radiology Reports

☐ All of the Above ☐ Other *(please be specific)* _____

*Please note that this report will include the sex of your embryos

## Please Select One of the Following Options:

☐ Records Released to MD:

| | |
|---|---|
| Receiving Provider: | Practice Name: |
| Phone Number: | Fax Number: |
| Email: | |

☐ Personal Request (Please Choose Option Below to Receive Records):

☐ Pick up in office (which location):

☐ Patient Email Address:

☐ Mailing Address:

## Reason for Request (Select all that apply):

☐ Personal Records ☐ Second Opinion ☐ Consultation/Referral ☐ Insurance ☐ Copy to Primary Provider

☐ Copy to Ob/Gyn ☐ Moved/Relocated ☐ Transfer to another Facility

☐ Other *(please specify)* _____

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.
5. 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, care and treatment, records of Substance Abuse care and treatment, and records of Sexually Transmitted Disease care and treatment.

_____ _____

Signature of individual patient Date

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