Highly Personalized Fertility Care

# Laboratory Release Form

| Patient Information | | |
|---|---|---|
| Legal Name (Last, First, Middle Initial) | | |
| Date of Birth (MM/DD/YYYY)<br>/ / | Social Security Number<br>– – | Phone Number<br>( ) - |
| Address | | |

| Release Via (select one) | | |
|---|---|---|
| ◯ Pick Up at Office (circle one): Center City King of Prussia Langhorne Mechanicsburg Willow Grove | | |
| ◯ Mail Address if different from above: | | |
| ◯ Fax | Fax Number<br>( ) - | ◯ E-mail |

| Authorization |
|---|
| I hereby authorize a copy of the following to be released (Select all that apply): |
| ◯ All laboratory results |
| ◯ 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; and records of substance abuse care and treatment.** |

***PLEASE READ BEFORE SIGNING***

**Minors:** A minor patient's signature is required in order to release the following information relating to the minor: (1) reproductive care; (2) sexually transmitted diseases ; (3) substance abuse ; and (4) mental health conditions if age 14 years and older.

Patient Rights: I understand I do not have to sign this authorization in order to obtain health care benefits (treatment, payment, or enrollment). I may revoke this authorization at any time except to the extent already relied upon by sending a request in writing to: Reproductive Medicine Associates of Philadelphia, PC, 735 Fitzwatertown Road, Suite 2, Willow Grove, PA 19090. I understand that once the health information I have authorized to be disclosed reaches the noted recipient, that person or organization may re-disclose it, at which time it may no longer be protected under privacy laws. Unless revoked earlier, this authorization will expire one year from the date it is signed.

I understand I have the following rights to:

Receive a copy of my protected health information

Receive a copy of this signed form

Refuse to sign this form for authorization to disclose or release my protected health information

**By signing this page, I acknowledge that I have read and agreed to the terms of this release.**

Signature Date