Highly Personalized Fertility Care

Patient Information	
Legal Name (Last, First, Middle Initial)	Date of Birth (MM/DD/YYYY) / /

Releasing Provider		
Name of Provider/Office	Phone Number ( ) -	Fax Number ( ) -
Address	Specialty of Releasing Provider ◯ Primary Care ◯ Ob/Gyn ◯ Other:	

Release To (select one):

2025 Technology Parkway, #211 Mechanicsburg, PA 17050 Phone: 717-516-1620 Fax: 717-516-1621	833 Chestnut St. Suite C152 Upper Concourse Philadelphia, PA 19107 Phone: 215-922-1556 Fax: 215-922-1565	735 Fitzwatertown Rd. Suite 2 Willow Grove, PA 19090 Phone: 215-938-1515 Fax: 215-938-8756	320 Middletown Blvd. Suite 303 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

Release via: ◯ Mail ◯ Fax ◯ Patient Pickup

Authorization

I hereby authorize a copy of the following to be released to RMA of Philadelphia/RMA of Central Pennsylvania (Select all that apply):

◯ All healthcare information records

◯ 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.**

I understand that I may revoke this Authorization at any time by providing my written revocation to any RMA office address listed above. I understand that my revocation will not apply to information already retained, used, or disclosed in response to this Authorization, and that revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.

Unless sooner revoked, the automatic expiration date of this Authorization will be twelve (12) months from the date of signature.

I understand that authorizing the disclosure of this health information is voluntary and you have my consent to release medical records for all dates including all diagnostic tests of any type and reports, history, hospitalization, diagnosis, prognosis, treatment, medication and pharmacy records, correspondence, consults, statement of charges or expenses. Any and all reports of any type or character.

I understand that the information authorized for release may include records which may indicate the presence of a communicable or non-communicable disease.

I understand I do not have to sign this authorization in order to obtain health care benefits (treatment, payment, or enrollment).

Information used or disclosed under this Authorization may be subject to re-disclosure by the recipient and no longer protected by federal privacy regulations.

By signing my name, I am attesting that I have read and agree to the terms listed above.

Signature Date

RecordRequest@rmaphiladelphia.com • Phone: 215-938-1515 • Fax: 215-938-8756