Highly Personalized Fertility Care

Authorization for Release of Patient Medical Records

There is a cost to release your medical records. For records over 10 pages, The charge is $23.04 for electronic copies and $29.19 for paper copies.

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

EMAIL	Scan/photograph the completed form and email to RecordRequest@rmaphiladelphia.com
FAX	Fax the completed form to: 215-938-8756
DROP OFF	the completed form in person at any of our five 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.

833 Chestnut Street
Suite C152
Upper Concourse
Philadelphia, PA 19107
Phone: 215-922-1556
Fax: 215-922-1565

735 Fitzwatertown Road
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

Fredricksen Outpatient Center
2025 Technology Parkway,
Suite 211
Mechanicsburg, PA 17050
Phone: 717-516-1620
Fax: 717-516—1621

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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)

Reason for Request (Select all that apply)

- ◯ Second Opinion
- ◯ Insurance Purposes
- ◯ Copy to Primary Care Provider
- ◯ Copy to Ob/Gyn
- ◯ Other (Please Specify):
- ◯ Moved out of area
- ◯ Urology Referral
- ◯ Other Referral
- ◯ Copy for my own use

Date of Appointment (if applicable):

I hereby authorize Reproductive Medicine Associates of Philadelphia, P.C. or Reproductive Medicine Associates of Central Pennsylvania to release my Protected Health Information to the following individual(s):

Self (Select One)

◯ Pick Up at Office: Center City King of Prussia Langhorne Mechanicsburg Willow Grove

◯ Mail Address if different from above:

◯ 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 (**except for HIV unless authorization is marked)**
◯ Psychological evaluations
◯ 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 it may take up to 15 business days to complete this 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 Assoc. of Philadelphia or Reproductive Medicine Assoc. of Central Pennsylvania, 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. or Reproductive Medicine Associates of Central Pennsylvania. 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. or Reproductive Medicine Associates of Central Pennsylvania.

I understand that I will be charged for the release of my medical records, at a rate of $23.04 (electronic) or $29.19 (paper) if my records exceed ten pages.

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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Credit Card Authorization

I hereby give my fully-informed consent, and agree to allow **Reproductive Medicine Assoc. of Philadelphia, P.C. or Reproductive Medicine Assoc. of Central Pennsylvania** to charge/debit my card, listed below.

Patient's Information, if not Cardholder	
Legal Name (Last, First, Middle Initial)	Date of Birth (MM/DD/YYYY)
Address	

By signing this credit card authorization, I give Reproductive Medicine Assoc. of Philadelphia, P.C. or Reproductive Medicine Assoc. of Central Pennsylvania permission to charge the credit card listed below for services provided to the patient, listed above.

Credit Card Information	
Card Number	Card Type: Visa MC Discover
Expiration Date	Security Code
Printed Name	Date of Birth (MM/DD/YYYY)
Signature	

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