Authorization for Release of Patient Health Information

Patient Name: _____ **Date of Birth:** _____

- **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 5-7 business days.**
- **There is a $10 fee per request for medical records; a credit card authorization form is attached.**
- **Partners need to complete a separate Authorization for Release of Patient Health Information.**

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

☐ Laboratory Reports ☐ HIV/Infectious Disease Panel ☐ Radiology/Ultrasound Reports ☐ Office Visit Notes

☐ Embryonic Genetic Testing (PGD/CCS/Single Gene)

☐ ***With*** *Gender information included* **OR** ☐ ***Without*** *Gender information included*

☐ Other *(please be specific)* _____

☐ **Records Released to MD:**

Receiving Provider: _____ **Office Location:** _____

Phone Number: _____ **Fax Number:** _____

Email: _____

☐ **Personal Request:**

Name: _____ **DOB:** _____ **Last 4 Digits of SSN:** _____

Patient Email Address: _____

Mailing Address: _____

_____

Description or the purpose of the use and/or disclosure:

☐ Personal Records ☐ Second Opinion ☐ Consultation/Referral ☐ Insurance

☐ Other *(please describe)* _____

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 of individual patient Date

This authorization will expire twelve months after it is signed.

The Source for New Beginnings
RMA

Credit Card Authorization Form

Patient Name: _____

Name as it appears on card: _____

Billing Address:

_____

_____

Phone #: _____

Payment Information

Accepted payment Methods:

16 Digit Card Number: _____

Expiration Date (MM/YYYY): _____

3 Digit Security Code: _____
(On the back of the card in signature box)

4 Digit Amex Security Code: _____
(Last four digits on front of the card above ID)

I, _____, hereby authorize RMA of FL, LLC to charge the above credit card in the amount of $ _____. I understand that by signing below I am responsible for payment of the described charges in accordance with the terms of the issuing credit card company.

Signature: _____ Date: _____
(Authorized Credit Card Holder)

Signature: _____ Date: _____
Patient