The Source for New Beginnings
RMA
Reproductive Medicine Associates of New Jersey
IVIRMA Global

Authorization for Release of Pregnancy Discharge Records.

Please complete the Authorization form and return it 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:
RMANJ
Attn: Medical Records
140 Allen Road
Basking Ridge, NJ 07920

Drop Off the completed form in person to any of our ten office locations.

There is no cost associated with this request.
Any additional requests for records will be subject to our medical records fee of $1 per page up to a maximum fee of $50.
Images will be provided to you at your final visit with us. Any additional requests are subject to a $25 fee.

If your partner needs a copy of his or her medical records, he/she must fill out their own copy of this form. Their first copy will be at no charge and any additional requests are subject to a fee.

To ensure accurate and timely release of records, please print legibly in black or dark ink.

Please ensure that all information is complete and accurate. Any errors or missing information may delay the release of your records.

We may need to request that you complete an additional form for email consent if we do not already have one on file and you are requesting your records electronically.

If you require further assistance, please do not hesitate to contact our office at 973-656-2865.

We appreciate your cooperation.

Authorization for Release of Patient Health Information
Discharge Release Form

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 this medical records request will be processed within 4 business days.**
- **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 needs to complete a separate release form in order to receive his/her own records.**
- **I understand that any records from another facility will not be included in this release.**
- **I understand that there is no charge for this request but there will be a fee assessed for any additional requests.**

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

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

☐ Other *(please be specific)* _____

Records Released to Patient:

□ In Person □ Via E-Mail □Via Mail

Patient Email Address: _____

Mailing Address: _____

_____

Permission to release additional records to OBGYN upon request

☐ **Records Released to MD:**

Receiving Provider: _____ Office Location: _____

Phone Number: _____ Fax Number: _____

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

☐ Discharge to OBGYN

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 unless otherwise revoked by the patient.