Reproductive Medicine and Surgery Center of Virginia, PLC
www.RMSCVA.com

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Phone: (434) 654-8520 Fax: (434) 654-8521

Authorization for Release of Medical Information

Patient's name: _____ Date of Birth: _____
Address: _____
City/State/Zip Code: _____
SS#: _____ Patient's phone #: ( ) _____

☐ I authorize RMSCVA, PLC **to release information to**:	**OR**	☐ I authorize RMSCVA, PLC **to obtain information from**:
_____ Name of Provider or Facility		_____ Name of Provider or Facility
_____ Address		_____ Address
_____ City, State, Zip Code		_____ City, State, Zip Code
_____ Phone #/Fax # (include area code)		_____ Phone #/Fax # (include area code)

The above mentioned provider/facility is authorized to release the requested health information for the following dates of service or range of events: _____

PURPOSE FOR THIS REQUEST: (Check one.) ☐ Healthcare ☐ Insurance coverage ☐ Personal ☐ Other ☐ Transfer of Care

TYPE OF RECORDS REQUESTED: (Check one.)
☐ Discharge Summary ☐ Psychiatric Evaluation ☐ Office/Clinic Notes ☐ Lab/Pathology Reports
☐ History & Physical ☐ Procedure/Operative report ☐ Radiology Reports ☐ Emergency Room Records
☐ Consultation Report ☐ Billing Information ☐ Entire Records
☐ Other _____

I understand that:

- My right to healthcare treatment is not conditioned on this authorization unless it is for the sole purpose of obtaining information for a research study. A copy of this authorization will be included with my original records.
- I may cancel this authorization at any time by submitting a ***written*** request to the address provided at the top of this form, except where a disclosure has already been made in reliance on my prior authorization. I understand 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.
- If the person or facility receiving this information is not a health care or medical insurance provider covered by privacy regulations, the information stated above could be redisclosed.
- This authorization will expire when the information from the event/purpose noted above is released to the recipient named in this document.
- That the information being released may include information relating to treatment of drug or alcohol abuse, sickle cell anemia, psychological or psychiatric impairments, sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), and/or human immunodeficiency virus (HIV).
- I have read (or had read to me) the above authorization and I understand my rights with regarding to my protected health information

Print Name of Patient or Representative _____

Signature _____ Date _____

Relationship to Patient: ☐ Self ☐ Spouse ☐ Parent ☐ Guardian ☐ Power of Attorney