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

595 Peter Jefferson Parkway
Suite 390
Charlottesville, VA 22911
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:

_____
Name of Partner

_____
Date of Birth

_____
Address

_____
City, State, Zip Code

_____
Phone #

The above mentioned provider/facility is authorized to release the requested health information for the following dates of service or range of events: this is in effect until revoked in writing by the patient.

PURPOSE FOR THIS REQUEST: (Check one.) x 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:

- These test results may affect the treatment recommendations and plans directed to my spouse/intimate partner.
- 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.
- 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 understand that I have the right to refuse to sign this authorization and that my treatment will not be conditioned on signing.
- 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