Authorization for Disclosure of Protected Health information

ima | Healthcare
Internal Medicine Associates

Instructions: Fill out each section of the form in its entirety. Failure to do so may delay in processing of your request.

Patient Name: _____ Date of Birth: _____

Full Address: _____

Phone Number: _____

Maiden/Previous Names: _____

Release of Information From:

Name/Facility: _____

Address: _____

_____

City/State/Zip: _____

Phone: _____

Release of Information To:

Name/Facility: _____

Address: _____

_____

City/State/Zip: _____

Phone: _____

Purpose of Release:

- ☐ Continuing Medical Care
- ☐ Insurance Claim
- ☐ Application for Insurance
- ☐ Other: _____
- ☐ Worker's Comp
- ☐ Disability Determination
- ☐ Personal

Information to be Released: Service Dates from: _____ To: _____ **or** ☐ all future records

- ☐ Complete Medical Record
- ☐ History & Physical
- ☐ Procedure Reports
- ☐ Imaging Reports/ Images
- ☐ Admit/Discharge Summaries
- ☐ ER Reports
- ☐ Alcohol/Drug Treatment Records
- ☐ Lab/Pathology Reports
- ☐ Psychological Eval/Assmts
- ☐ EKG & Cardiology Reports
- ☐ Medications
- ☐ Consultations
- ☐ Immunizations
- ☐ Final Diagnosis
- ☐ Other (specify): _____

NOTE: This authorization expires form one year from the date of my signature unless I specify a different event, purpose, or alternative, expiration date here: _____

I AUTHORIZE RELEASE OF ALL ALCOHOL AND/OR DRUG TREATMENT RECORDS THAT ARE PART OF THE RECORDS I SEPCIFIED ABOVE UNLESS OTHERWISE INDICATED BELOW:

_____ Do not release alcohol or drug treatment records protected under federal law.

I may revoke this authorization at any time by sending written notice to the facility/provider releasing records. A revocation is not valid if (1) action was previously taken in reliance on this authorization, or (2) if this authorization was obtained as a condition for obtaining insurance coverage. I authorize the facility/provider to disclose medical information to the party identified in the "Release of Information To" section. I understand this may include information regarding mental health, alcohol/drug use, and HIV treatment. I understand that once disclosed, information may be re-disclosed by the recipient and no longer protected. I understand this authorization is voluntary and that I may refuse to sign. Unless allowed by law, my refusal to sign will not affect my ability to obtain treatment, receive payment, or my eligibility for benefits.

Signature (required): _____ Date Signed (required): _____

Printed Name of Person Signing (if not patient): _____