

iMED INTERNAL MEDICINE
Authorization Form
For Release of Protected Health Information
Medical Records Voicemail #: 210-404-0000 Ext. 188 Medical Records Fax #: 210-581-0120

Patient Name: _____ Birth Date: _____
Social Security Number: _____

HIV / AIDS: I consent to the release of any positive or negative test result for AIDS or HIV infection, antibodies to AIDS or infection with any other causative agent of AIDS with the rest of my medical records. I acknowledge and hereby consent to such, that the released information may contain alcohol, drug abuse, psychiatric or AIDS information. Initial: _____ Date: _____

I hereby authorize: Facility/Doctor _____
Address _____
Phone/Fax # _____

The health information you may release subject to this authorization is as follows:

- | | |
|----------------------------------------------------|--------------------------------------------------------------|
| <input type="checkbox"/> Entire Record | <input type="checkbox"/> Office Visits from ____ to ____ |
| <input type="checkbox"/> Labwork from ____ to ____ | <input type="checkbox"/> Radiology reports from ____ to ____ |
| <input type="checkbox"/> Consultation reports | <input type="checkbox"/> Pathology reports |
| <input type="checkbox"/> Medication reports | <input type="checkbox"/> Other _____ |

To release my protected health information to the following person(s)/entity:

Name: _____
Street: _____
City: _____ State: _____ Zip: _____

The reasons or purposes for this release of information are as follows:

This authorization shall be in force and effective until the following event and/or date: _____

I understand that:

- I may refuse to sign this authorization and that it is strictly voluntary.
- I understand that I have the right to revoke this authorization at any time in writing.
- I understand that a revocation is not effective to the extent that the practice has relied on this authorization in its action. Also, a revocation is not effective if this authorization was obtained as a condition of obtaining insurance coverage, as other law provides the insurer with the right to contest a claim under the policy or the policy itself.
- I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal HIPAA privacy regulations.
- I understand that I may see and obtain a copy of the information described on the form, for a reasonable copy fee, if requested by patient.

By signing this form, I authorize you to use and disclose the protected health information as stated.

Signature of Patient/Patient Representative _____ Date _____

Print Name of Patient/Patient Representative _____

Description of Relationship if Patient Representative _____

Medical Records Fee Schedule:

First 20 pages: \$25.00

Each additional page: \$.50

If medical records are requested from another physician's office there will be no copying fee.

Once the Medical Release Form has been completed please do the following:

1. Fax the Medical Record Release Form to 210-581-0120.
2. Please allow 7-14 business days for request to be completed.
3. Please call the Medical Records Voicemail to follow up on any requests that have not been received after 14 business days.