

iMED INTERNAL MEDICINE
Authorization Form
For Release of Protected Health Information

Patient Name: _____ **Physician:** _____

Birth Date: _____ **Social Security Number:** _____

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 _____ |

<p>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</p> <p style="text-align: right;">Initial: _____ Date: _____</p>

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

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 redisclosure 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 I ask for it.
- My treatment, payment, enrollment or eligibility for benefits may not be conditioned on signing this authorization.

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 _____