



Authorization to Release Protected Health Information (HIPAA Compliant Request for Information/Medical Records)

Please Complete this Entire Form. Incomplete Authorizations are Invalid.

_____		_____		
Name of Patient		Street Address		
_____		_____		
Phone Number		City	State	ZIP Code
_____		_____		XXX-XX-____
Maiden (or other) Name		Date of Birth		Last 4 digits of S.S. #

I hereby give IGO Medical Group, AMC permission to release my Protected Health Information (PHI) also known as My Medical Records.

Please choose the method of delivery by checking the preferred option and filling out the information where required. Be certain that information is accurate and complete. Incomplete authorizations are invalid.

<input type="checkbox"/> U.S. Mail to my personal address. <i>(Records will be mailed to the address listed above.) (Subject to Copy Charges)</i>	<input type="checkbox"/> Please send my records to the following: _____ Name of Medical Office/Company/Entity you want to receive the records.
<input type="checkbox"/> I prefer to pick up my records personally. Please call me when they are ready. <i>(Photo ID will be required for pick up.) (Subject to Copy Charges)</i>	_____ Street Address
	_____ City State ZIP Code
	_____ Phone Number Fax Number

The Protected Health Information (PHI) I would like to have released is as follows:

Release a copy of my entire chart. Release records for this specific date of service _____

Release the following specific information _____

I am requesting my PHI to be disclosed for the following reason _____

This authorization shall expire one year from the date of signature, or at the following event _____

I understand the recipient may not further use or disclose the medical information unless another authorization is obtained from me or unless such use or disclosure is specifically required or permitted by law.

I do not give permission for any other use or redisclosure of this information. I understand that this authorization will automatically expire one year from the date executed. I understand I may revoke this consent at any time in writing, except to the extent that action has already been taken.

I understand that I have a right to receive a copy of this authorization upon my request.

_____		_____	
Patient Signature		Date	
_____		_____	
Witness Signature		Date	