



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

|                        |  |                |                        |                        |
|------------------------|--|----------------|------------------------|------------------------|
| _____                  |  | _____          |                        |                        |
| Name of Patient        |  | Street Address |                        |                        |
| _____                  |  | _____          |                        |                        |
| Phone Number           |  | City           | State                  | ZIP Code               |
| _____                  |  | _____          |                        | XXX-XX- ____ ____ ____ |
| Maiden (or other) Name |  | Date of Birth  | Social Security Number |                        |

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