



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

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

I hereby give permission to release my Protected Health Information (PHI) also known as My Medical Records.
Be certain that information is accurate and complete. Incomplete authorizations are invalid.

Name of Medical Office/Company/Entity you want to **send** records to IGO.

Street Address

City State ZIP Code

Phone Number Fax Number

Please send My Records to:

IGO Medical Group, AMC
9339 Genesee Avenue, Suite 220
San Diego, CA 92121-2121
FAX 858-455-6816

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 _____
(Including x-rays and lab reports)

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 this information may be subject to re-disclosure by the recipient and no longer protected by the privacy rule. I release you from all liability that may arise from your compliance with this request to release records.

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