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
Phone 858-455-7520 FAX 858-554-1312

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

☐ Release a copy of the previous 2 years records. *(Including x-rays and lab reports)*

☐ Release a copy of the records from the following specific date range _____

☐ 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