IM CLINIC
The Internal Medicine Clinic

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Authorization to Release Medical Records

Patient Name **Date of Birth** (mm/dd/yyyy) **SSN**

Physician to provide records

Doctor / Practice Name **Address** **Phone**
Fax

Records

The undersigned patient hereby authorizes the release of the following records:

☐ **All medical records**

☐ Most recent clinic or consult note
☐ History & Physical
☐ Discharge Summary

☐ Information specifically regarding

☐ Procedure reports
☐ Operative reports

☐ Pathology reports
☐ Laboratory test results
☐ Imaging reports

☐ Other

Consents

- I understand that I may change my mind and revoke this Authorization at any time in writing, except to the extent the releasing party has already relied upon this Authorization.
- I understand that protected health information disclosed based on this Authorization may be re-disclosed by the receiving person or entity and may no longer be protected from disclosure to others by federal or state law.
- I understand that protected health information disclosed based on this Authorization may include mental health treatment, alcohol or drug abuse treatment and/or sexual health treatment including HIV/AIDS related information. I authorize release of all medical information concerning these diagnoses and/or treatment of these conditions, to the extent included in the records identified above.
- I understand that neither IM Clinic LLC nor the releasing party may condition my treatment on my execution of this Authorization to Obtain Protected Health Information.
- I understand that this Authorization expires one year from the date of signature.
- I acknowledge that the party releasing my records will not receive payment or other remuneration from a third party in exchange for using or disclosing my protected health information.
- I acknowledge that a copy of this authorization may be utilized with the same effectiveness as an original.

Signature **Date**