IMS
Integrated Medical Services

Authorization for Release of Medical Records

Patient Information Last Name _____ First Name _____

Medical Record Number (M.R.N.): ***OR*** Social Security Number (S.S.N):	Date of Birth (D.O.B):
Address:	City:
State:	Zip Code:
Primary Telephone Number:	Primary Email Address:

Provider/Medical Practice Information

Provider Name:	Medical Practice Name:
Address:	City:
State:	Zip Code:
Primary Telephone Number:	

I hereby authorize Integrated Medical Services, Inc. to disclose my Protected Health Information (PHI) described below to the following:

Name and Address of Individual/Company/Facility to whom PHI may be disclosed

Individual/Company/Facility Name:	
Address:	City:
State:	Zip Code:
Primary Telephone Number:	

This authorization permits the disclosure of the following information

I am requesting the following records (check all that apply)

☐ Medical Records ☐ Billing Records

Please provide medical information from the following dates: From: To:

Reason for Request

☐ Patient's Personal Use
☐ Insurance release
☐ Other Please Specify:
☐ Continuation of Care (New PCP or Specialist)
☐ Legal

If there is something you do not want released, please specify below

_____

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I understand:

- *I may revoke this Authorization at any time by submitting a written request in person. Any request for revocation will not apply to information already used or disclosed pursuant to this Authorization.*
- *Unless otherwise revoked in writing, this Authorization will automatically expire one (1) year from the date of my signature below.*
- *I release IMS as well as its agents and employees from any liability in connection with the use or disclosure of the Protected Health Information covered by this authorization. IMS will not be compensated by the recipient for the disclosure, except for the cost of copying and mailing as authorized by law.*
- *Information used or disclosed pursuant to this Authorization may be subject to re-disclosure by the recipient and no longer protected by federal law. However, the recipient may be prohibited from re-disclosing substance abuse information under the Federal Substance Abuse Confidentiality Requirements.*
- *I have the right to inspect the health information to be released, and I may refuse to sign this Authorization.*
- *By signing this release form you are agreeing to release information regarding, but not limited to: Psychiatric Treatment Notes / Mental Health Information; Pregnancy Screening / Family Planning; HIV/AIDS; STD screening and other related information; Communicable Diseases; Domestic Violence / Sexual Assault; Alcohol and Substance abuse information; Abortion information; Genetic Information.*

Signature of Patient or Legal Representative	Name of Patient or Legal Representative	Date

Staff Witness Initials: ***Date Request Received:***

Important Note

Some practices may use an outside record copying company for serving medical records request. For information on charges for records or any other questions on your records, please contact your provider's office.

- Please bring in this form to your provider's office from which you are requesting medical records.
- Records Requests that are partially complete may be returned and delayed

YOU HAVE THE RIGHT TO REQUEST A COPY OF YOUR SIGNED AUTHORIZATION FORM