IMS
INTEGRATED MEDICAL SERVICES

9250 N. 3RD. ST., Suite 4010
PHOENIX, AZ 85020
Phone: 602-633-3838

Authorization to Disclose Health Information

Patient Information:

Medical Record or Social Security # _____

Patient Full Name: _____

Address: _____ Date of Birth: _____

City: _____ State: _____ Zip: _____ Phone : _____

Release Information To:

I hereby authorize Integrated Medical Services to disclose my Protected Health Information (PHI) described below to:

Name : _____

Address: _____ Phone: _____

City: _____ State: _____ Zip: _____ Fax: _____

Purpose of Request: □ Personal □ Legal □ Insurance □ Treatment/Continuity of Care □ Other_____

Information to be Released:

IMS Provider/Practice _____

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

Please provide information in my medical record for dates:

□ Medical Records
□ Billing Records

From_____To_____

*Unless othewise specified the past two years of pertinent information will be sent

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Authorization:

I understand:

- 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.
- 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, unless otherwise specified on this 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.
- I may revoke this Authorization at any time by submitting a written request. Any request for revocation will not apply to information already used or disclosed pursuant to this Authorization.

Patient's Signature_____ **Date:**_____

(Required for all patients 18 years and older for psychiatric records, 14 years and older for substance use records)

Signature of Parent or Legal Guardian_____ **Date:**_____

(Required for all patients under the age of 18 unless otherwise allowed by law. If not the parent, legal representation documentation must be supplied)

Imporant Notes:

Please bring in this form to the providers office from which you are requesting records.

Forms that are partially completed may be returned.