INTERNAL MEDICINE ASSOCIATES, LLC
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AUTHORIZATION TO USE AND/OR DISCLOSE HEALTH INFORMATION
(REQUEST FOR RELEASE OF MEDICAL RECORDS)

I, _____, date of birth _____, authorize Internal Medicine Associates, LLC. to use and/or disclose my health information to: **Myself** and/or _____.

I authorize disclosure of the following types of health information

Types of Health Information *If not checked, default is ALL TYPES*	**Date(s) of Service for requested records** *If left blank, default is ALL DATES*	**For the following purpose(s)** *If not checked, default is CONTINUATION OF CARE*
☐ Office/ Provider Notes	_____	
☐ Laboratory Reports	_____	☐ Continuation of Care
☐ Pathology and Biopsy Reports	_____	☐ Personal Request
☐ Imaging Studies	_____	☐ Insurance Claims
☐ Billing Statements	_____	☐ Legal Request
☐ Other: _____	_____	☐ Other:_____

* The following items must be initialed to be included in the use or disclosure of other health information:

_____ *HIV/HCV/AIDS / SEXUALLY TRANSMITTED related health information and/or records

_____ *Mental health information and/or records

_____ *Drug/alcohol diagnosis, treatment and/or referral information (Federal regulations require a description of how much and what kind of information is to be disclosed. Federal law prohibits the re-disclosure of such information): _____

Except to the extent that action has already been taken in reliance upon this authorization, I understand that I may revoke this authorization at any time by giving written notice to **the Practice Manager or the Privacy Officer**. I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment, payment, enrollment or eligibility for benefits. I may inspect or copy any information to be used or disclosed under this authorization. I understand I have a right to obtain a copy of this Authorization, upon requesting. **I understand that this form does not supersede any previously signed Release of Information.**

I also understand that, if the person or entity receiving this information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be redisclosed and no longer protected by these regulations. However, the recipient may be prohibited from disclosing my health information under other applicable state or federal laws and regulations.

_____ _____
Signature of Individual or Individual's Legal Representative | Date Signed (Expires one year after signature)

_____ _____
Print Name of Legal Representative (if applicable) | Relationship of Legal Representative to Individual