IPCAZ USE ONLY		
DATE OF RELEASE	IPCAZ EMPLOYEE INITIALS	
___EMAIL	___FAX	___P/U

AUTHORIZATION & RELEASE TO DISCLOSE MEDICAL RECORDS

Patient Name ______________________ Date of Birth ______________________

Phone # ______________________ Email ______________________

EFFECTIVE 8/1/15, THE CHARGE FOR COPIES OF PATIENT RECORDS (if records are going to patient):

_____***CD's ($5 paid at time of request)*** _____ ***Paper Copies ($35 paid at time of request)***

Release Medical Records From			**Release Medical Records To**	
Provider			Provider	
Address			Address	
City/St/Zip			City/St/Zip	
Phone	Fax		Phone	Fax

Patient is requesting the following medical records				
☐Office Notes	☐Lab Reports/Records	☐Radiology Reports	☐Procedure Reports	☐Other

In addition to the general authorization to release records, the undersigned further authorizes the individuals or entities listed above to provide a copy of the following records		
☐Records of treatment for drug or alcohol abuse	☐Records of treatment for psychiatric illness	☐Records of testing diagnosis or treatment of HIV, HIV-related illness, AIDS, AIDS-related diseases and communicable disease related information

Release my medical records for the following dates	
From	To

This authorization shall be considered invalid after six (6) months (or 60 days with respect to drug and alcohol abuse records) from the date of signing. The undersigned may revoke this authorization at any time by providing written notice of revocation; however the undersigned may not revoke authorization retroactively for information already released. With respect to any drug and alcohol abuse treatment information protected by federal confidentiality rules and release pursuant to this authorization, or records regarding communicable disease related information, the recipient of this information understands that it is prohibited from making any further disclosure of this information unless further disclosure is expressly permitted by written consent of the undersigned or otherwise permitted by applicable law.

I agree that this office may release records pertaining to my treatment to my insurance company or other third parties responsible for payment of my medical charges, including review activities related to my physician's participation with my health plan.

PLEASE NOTE: IF YOU WILL BE PICKING UP YOUR MEDICAL RECORDS, COPIES WILL BE HELD FOR YOU UP TO FOUR (4) WEEKS AFTER THE DATE THIS RELEASE HAS BEEN SIGNED.

Patient Signature ______________________ Date ______________________

Reason for leaving IPCAZ ______________________

Centers of Excellence
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