IPM MEDICAL GROUP INC
Treating pain, Restoring life

AUTHORIZATION TO TRANSFER MEDICAL RECORDS

1. **Patient Information:**
Name:_____DOB:_____
Address:_____
Phone Number:_____
Medical Record ID #:_____

2. **Authorization for Release:**
I hereby authorize:
_____Any medical provider providing care for my injury on or around_____.
_____Any medical provider providing care associated with my chronic pain treatment.
_____I request to provide individual approvals as needed.

To release, disclose and deliver medical information described below to:

medicalrecords@ipmdoctors.com

3. **Specific Authorization:** I specifically authorize the release of ALL medical information relating to the above/named patient including but not limited to the following categories protected by the state of federal law (1) Substance abuse (drug/alcohol) treatment; (2) Mental Health treatment; and (3)HIV-AIDS related information, if such correspondence, test, results, and any other information in the records, whether generated by the authorized provider or another entity.

I do not give permission for any other use or disclosure of this information.

Patient Signature_____Date_____

4. **Re-Disclosure.** This release does not authorize re-disclosure of medical information beyond the limits of this consent. The recipient of this information is prohibited from using the information for other than the stated purpose and from disclosing it to any other party without further authorization. The following written statement should accompany certain disclosures.