IPM
MEDICAL GROUP INC
Treating pain, Restoring life

HIPAA AUTHORIZATION FOR TRANSMISSION OF MEDICAL RECORDS

This form is for a patient to request the release and transmission of their medical records when such authorization is required and complies with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) Privacy Standards.

Patient Information:

Name: ____

Date of Birth:____________________SSN: ________________

Address: ____

I. My Authorization

I authorize, and request, Integrated Pain Management Medical Group, Inc.

to use and disclose the following health information (check all that apply).

☐ - Physician Progress Notes

☐ - Operative Reports

☐ - Laboratory Test Results

☐ - Psychological Test Results

☐ - All clinical notes created by IPM in the course of my medical treatment

The above party may transmit this health information to the following recipient (if requesting your own records, input your information):

Name (or title) and organization ____________________________________

Address ____

City__________________State____________________Zip ___________________

Phone_________________Fax____________________Email ___________________

I authorize records to be transmitted to the above party via:

☐ Email (Free of charge) ☐ Fax (Free of charge)

☐ Physical Mail

II. My Rights

I understand that I have the right to revoke this authorization, in writing, at any time, except where uses or disclosures have already been made based upon my original permission. I may not be able to revoke this authorization if its purpose was to obtain insurance. In order to revoke this authorization, I must do so in writing and send it to the appropriate disclosing party.

I understand that uses and disclosures already made based upon my original permission cannot be taken back.

I understand that it is possible that information used or disclosed with my permission may be re-disclosed by the recipient and is no longer protected by the HIPAA Privacy Standards.

I understand that treatment by any party may not be conditioned upon my signing of this authorization (unless treatment is sought only to create health information for a third party or to take part in a research study) and that I may have the right to refuse to sign this authorization.

To authorize the transmission of your medical records, please sign three times, where indicated in yellow, below. Failure to sign in all three locations will result in termination of a request.

Signature of Patient: ____

Date: ___________

If the patient is a minor or unable to sign, please complete the following:

☐ - Patient is a minor:_____________years of age

☐ - Patient is unable to sign because: ____

Signature of Authorized Representative: ______________________________________

Date: ________________

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Print Name of Authorized Representative: ____

Authority of representative to sign on behalf of the patient:

☐ - Parent ☐ - Legal Guardian ☐ - Court Order ☐ - Other: ______________________

III. **Additional Consent for Certain Conditions**

This medical record may contain information about **physical or sexual abuse, alcoholism, drug abuse, sexually transmitted diseases, abortion, or mental health treatment**. Separate consent must be given before this information can be released.

☐ - I consent to have the above information released.

Signature of Patient or Authorized Representative: ______________________________

Date: ___________________

IV. **Additional Consent for HIV/AIDS**

This medical record may contain information concerning **HIV testing and/or AIDS diagnosis or treatment**. Separate consent must be given to have this information released.

☐ - I consent to have the above information released.

Signature of Patient or Authorized Representative: ______________________________

Date: ___________________

Please submit this completed request (signed three times, above) to medicalrecords@ipmdoctors.com. You will receive your medical records via fax, or email, within 10 business days.