

INSTITUTE FOR PROGRESSIVE MEDICINE

4 Hughes #175 Irvine, CA 92618 Tel. (949) 600-5100 Fax (949) 600-5101

Authorization for Release of Medical Information

I hereby authorize _____
(Name of Physician, Medical Group or Hospital)

Address _____ City _____ State _____ Zip _____ Telephone _____ Fax _____

To release my medical records to: Institute for Progressive Medicine Tel. 949-600-5100
4 Hughes Road, STE. 175 Fax 949-600-5101
Irvine, CA 92618

Information to be released: _____ ALL MEDICAL RECORDS
_____ OTHER _____

By signing this form, I hereby authorize reciprocal information to be shared between the above named parties or agencies. I hereby authorize the release of any and all information, including information regarding alcoholism, drug abuse, mental illness or HIV infection, pertaining to my medical condition.

This authorization is effective immediately and is subject to revocation at any time, except to the extent that action has already been taken. Otherwise, the authorization expires 90 days from the date of **SIGNING**.

I realize that this is a required consent and that I must voluntarily and knowingly sign this authorization **BEFORE** any records can be released. I may refuse to sign, but in that event, the records cannot be released.

I further release my attending physician, consultants, the facility, and employees from any liability arising from the release of information to the person(s) or agency designated above.

I understand that I have a right to receive a copy of this authorization upon my request.

Patient's Name _____ Date of Birth _____

Address _____ Soc. Sec. No. _____

City _____ State _____ Zip _____ Phone No. _____

Signed _____ Date _____
(Signature of patient/Parent/Patient's Legal Representative*)

Relationship to Patient _____

*Authorized representative must submit copies of legal documents supporting assignment of this authority.