Institute for Progressive Medicine

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iprogressivemed.com

Authorization for Release of Medical Information

I hereby authorize The Institute for Progressive Medicine to release my medical records to:

_____

(Name of Physician, Medical Group or Hospital)

_____

Address City State Zip Telephone Fax

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_____

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.