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Advanced Internal Medicine, PC
AIM for Better Health

Authorization to Release Medical Records

Patients Name:_____ Date of Birth:_____

Other Name(s):_____ Phone #:_____

Pt's Address:_____

TO: _____

_____

Ph #: _____ Fax#: _____

I HEREBY AUTHORIZE YOU TO RELEASE MEDICAL RECORDS TO: ADVANCED INTERNAL MEDICINE

Date(s) of Treatment:_____

PURPOSE: ___Personal ___Medical ___Legal ___Insurance ___Other:_____

Copies Of: ___Progress Notes ___Imaging___ EKG ___Labs ___Other:_____

It is understood this consent is subject to revocation at any time except to the extent that action has been taken in reliance thereon. In the absence of express revocation, this consent shall expire in ninety (90) days from the date of signature. Considering this authorization, I hereby waive all provisions of law any privileges relating the disclosures authorized.

Once healthcare information is disclosed, the person or organization that receives it may re-disclose it. Privacy laws may no longer protect the information.

Patient Signature: _____ Date:_____