Specialists in Internal Medicine, PA

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Authorization to Release/Obtain Medical Information

USE THIS FORM TO HAVE RECORDS SENT TO OR FROM YOUR PROVIDER AT SIMPA

Patient Name _____ DOB___/___/___ Former Name _____

Address _____ City, _____ State: _____ Zip: _____

Daytime Phone _____ Evening Phone _____ SS#_____

Purpose of Release: check one box:

☐ Changing Provider ☐ Insurance ☐ Referral/Consultation ☐ Legal ☐ Other

☐ I authorize the release of my medical records be sent to: **Specialists in Internal Medicine, P.A.**

Facility Name: _____ **Attn**: Medical Records
Address: _____ City: _____ State: ____ Zip: _____

☐ I authorize Specialists in Internal Medicine to **release/send** my medical records to:

Facility Name: _____
Address: _____ City: _____ State: ____ Zip: _____

INDICATE TYPE OF INFORMATION TO BE RELEASED BELOW

☐ **General Medical Records**
(copies of last two years of information including progress notes, lab and imaging reports, and immunizations; other information furnished upon request)

-OR- **Specific Information Only:**
☐ History and Physical Specify Date _____
☐ Medications/Therapy
☐ Lab, Pathology, EKG Specify Date _____
☐ Imaging Specify Type & Date _____
☐ Immunizations
☐ Other _____

Protected or sensitive information: I understand that certain information cannot be released without specific authorization as required by State/Federal law. BY INITIALING BELOW, I authorize the release of the following protected or sensitive information:

_____ DRUG ABUSE DIAGNOSIS/TREATMENT
INITIAL

_____ ALCOHOLISM DIAGNOSIS/TREATMENT
INITIAL

_____ MENTAL HEALTH/TREATMENT
INITIAL

_____ SEXUALLY TRANSITTED INFECTIONS
INITIAL

_____ AIDS/HIV TEST RESULTS INCLUDING HIGH RISK BEHAVIOR
INITIAL

_____ GENETIC TESTING TREATMENT
INITIAL

By signing this form, you are authorizing use or disclosure of your protected health information as described above. This information may be redisclosed if the recipient is not required by law to protect the privacy of the information. You are under no obligation to sign this form. You have the right to revoke this authorization at any time. If you revoke, the information described above may no longer be used or disclosed. The request to revoke must be in writing. Unless revoked, this authorization will expire 365 days from the date of signing.

_____ _____ _____
Signature of Patient or Legally Responsible Person | Relationship to Patient | Date

Revised: 2/20/2017