IGO Infertility, Gynecology & Obstetrics
MEDICAL GROUP, AMC

Authorization to Release Protected Health Information

(HIPAA Compliant Request for Information/Medical Records)

Please Complete this Entire Form. Incomplete Authorizations are Invalid.

_____ _____
Name of Patient Street Address

_____ _____
Phone Number City State ZIP Code

_____ _____ XXX-XX- ___ ___ ___ ___
Maiden (or other) Name Date of Birth Last 4 digits of S.S. #

I hereby give IGO Medical Group, AMC permission to release my Protected Health Information (PHI) also known as My Medical Records.

Please choose the method of delivery by checking the preferred option and filling out the information where required. Be certain that information is accurate and complete. Incomplete authorizations are invalid.

☐ U.S. Mail to my personal address.
(Records will be mailed to the address listed above.)
(Subject to Copy Charges)

☐ I prefer to pick up my records personally. Please call me when they are ready.
(Photo ID will be required for pick up.)
(Subject to Copy Charges)

☐ Please send my records to the following:

_____
Name of Medical Office/Company/Entity you want to receive the records.

_____
Street Address

_____
City State ZIP Code

_____
Phone Number Fax Number

The Protected Health Information (PHI) I would like to have released is as follows:

☐ Release a copy of the previous 2 years records.

☐ Release a copy of the records from the following specific date range _____

☐ Release the following specific information _____

I am requesting my PHI to be disclosed for the following reason_____

This authorization shall expire one year from the date of signature, or at the following event _____

I understand the recipient may not further use or disclose the medical information unless another authorization is obtained from me or unless such use or disclosure is specifically required or permitted by law.

I do not give permission for any other use or redisclosure of this information. I understand that this authorization will automatically expire one year from the date executed. I understand I may revoke this consent at any time in writing, except to the extent that action has already been taken.

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

_____ _____
Patient Signature Date

_____ _____
Witness Signature Date

9339 Genesee Avenue, Suite 220, San Diego, CA 92121 Phone 858-455-7520 FAX 858-554-1312