Medical Records Release Form

Integrative Medical Associates
1098 Foster City Blvd. #305
Foster City, CA. 94404
Phone: 650-474-2130 Fax 650-474-2136

Patient Name:_____Date of Birth _____ Acct:_____
(Office use only)

1. Please check one of the following:

A. _____I hereby authorize Integrative Medical Associates to **obtain** the following information from health records of the patient indicated above.

B. _____I hereby authorize Integrative Medical Associates to **disclose** the following information from health records of the patient indicated above.

C. _____I would like to **obtain** my health records from Integrative Medical Associates. I understand and authorize IMA to release the records to me and that there may be a medical records charge.

2. Obtained From_____

3. Disclosed to: _____

Address_____Phone_____

Please include records covering the period (s) of health care: From_____To_____
Date Date

4. Information to be disclosed:

___Complete health record(s)
___History & physical examination
___Consultation reports
___X-ray Reports
___Discharge summary
___Progress notes
___Laboratory tests
___Photographs, videotapes, digital other images
___Other (please specify)_____

I understand that this will include information relating to (check if applicable)
___Acquired immunodeficiency syndrome (AIDS)
___Human immunodeficiency syndrome (HIV)
___Behavioral health service/psychiatric care
___Treatment for alcohol and/or drug abuse

5. I understand this authorization may be revoked in writing at any time, except to the extent that the action has been taken in reliance on this authorization. Unless otherwise revoked, this authorization will expire on the following date, event or condition: _____

6. This facility, its employees, officers and physicians are hereby released from any legal responsibility or liability for disclosure of the above information to extent indicated and authorization herein signed:

_____ _____
Patient/or Legal Representative Date

_____ _____
Relationship to Patient Date

_____ _____
Signature of Witness Date