



**Authorization to Release Protected Health Information  
(HIPAA Compliant Request for Information/Medical Records)**

\_\_\_\_\_  
Name of Patient

\_\_\_\_\_  
Street Address

\_\_\_\_\_  
Phone Number

\_\_\_\_\_  
City

\_\_\_\_\_  
State

\_\_\_\_\_  
ZIP Code

\_\_\_\_\_  
Maiden (or other) Name

\_\_\_\_\_  
Date of Birth

\_\_\_\_\_  
XXX-XX-\_\_\_\_  
Social Security Number

**I hereby give permission to release my Protected Health Information (PHI) also known as My Medical Records.**  
*Be certain that information is accurate and complete. Incomplete authorizations are invalid.*

\_\_\_\_\_  
Name of Medical Office/Company/Entity you want to **send** records to IGO.

\_\_\_\_\_  
Street Address

\_\_\_\_\_  
City

\_\_\_\_\_  
State

\_\_\_\_\_  
ZIP Code

\_\_\_\_\_  
Phone Number

\_\_\_\_\_  
Fax Number

**Please send My Records to:**

**IGO Medical Group, AMC  
9339 Genesee Avenue, Suite 220  
San Diego, CA 92121-2121  
Phone 858-455-7520 FAX 858-554-1312**

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

- Release a copy of my entire chart.  Release records for this specific date of service \_\_\_\_\_  
*(Including x-rays and lab reports)*
- 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 this information may be subject to re-disclosure by the recipient and no longer protected by the privacy rule. I release you from all liability that may arise from your compliance with this request to release records.*

*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