OIMA
AN INDEPENDENT MEDICAL GROUP
WWW.OIMA.ORG
OVERLAKE INTERNAL MEDICINE ASSOCIATES

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All requests are billable

*****(Requests for information for a Physician or yourself will be subject to copying charges:**

$1.12/page for the first thirty (30) pages

and $0.84 per page thereafter.)***

Patient Name: _____ DOB: _____

Previous Name (*if any*): _____ SSN: _____

Information to be released by:

Organization: _____

Name: _____

Address: _____

_____

Information to be released to:

Organization: _____

Name: _____

Address: _____

_____

This request and authorization applies to:

_____ All healthcare information **(This is limited to the two (2) most current years of information including lab and X-ray reports.)**

_____ Additional healthcare information. Please specify number of years. _____

_____ Only healthcare information relating to the following treatment, condition, or dates of treatment.

Please specify_____

This authorization ends: (*This document does not permit disclosure of health information created more than 90 days after the date it is signed)*

☐ In 90 days from the date signed ☐ on (date):_____

☐ When the following event occurs: _____
(no longer than 90 days from date signed)

Purpose for which disclosure is being made: ☐Attorney ☐Insurance ☐Doctor ☐Personal

I understand that this authorization, unless expressly limited by me in writing, will extend to all aspects of treatment including testing and/or diagnosis for HIV/AIDS, sexually transmitted diseases, psychiatric disorders/mental health, or drug and/or alcohol use. If I have been tested, diagnosed, or treated for any of the above, you are specifically authorized to release all healthcare information relating to such diagnosis, testing, or treatment. My ability to obtain medical care is not conditioned upon signing this authorization.

I hereby release Overlake Internal Medicine Associates and its staff from all legal responsibility or liability that may arise from the release of the above mentioned information. I understand that my records are protected under Federal and State confidentiality laws and regulations and cannot be disclosed without my written consent unless otherwise provided for in said laws and regulations. I understand that once Overlake Internal Medicine Associates releases health information, the person or organization that receives it may re-disclose it, at which time it may no longer be protected under privacy laws. I may revoke this authorization, in writing.

_____ _____

Signature of patient or patient's authorized representative **Date**

Revised 12/24/15