**REQUEST FOR RELEASE OF HEALTH INFORMATION**

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, authorize \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ to release health information as indicated here:

Facility name/ Physician Name

Independent Physical Medicine

Fax: 877-813-6315

Phone: 567-940-9333

Address: 3469 West Elm Lima Ohio 45807

Nucleus: Independent Physical Medicine

*If there is a charge, please call the office to receive payment.*

\_\_\_ Please send images to Nucleus: Independent Physical Medicine

\_\_\_ Please provide X-ray/ MRI report via nucleus and or via facsimile (877-813-6315)

Information to include:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

ATTENTION: If there is any reason why this information cannot be released as requested, please notify the facility by phone immediately.

CONFIDENTIAL INFORMATION ENCLOSED TO BE VIEWED BY AUTHORIZED PERSONNEL ONLY. This facsimile transmission contains confidential information, some or all of which may be protected as defined by federal health portability and accountability act (HIPPA) privacy rule. This transmission is intended for the exclusive use of the individual or entity to whom it is addressed and may contain information that is confidential. If you are not the intended recipient (or employee or agent you are hereby notified that any disclosure, dissemination, distribution or copying of this information is strictly prohibited and may be subject to legal restriction or sanction. Please notify our facility by telephone to arrange the return of the destruction of this information and all copies.

I understand and acknowledge that the requested information may contain information regarding physical and mental illness, test results, diagnosis. Patient Information & Authorization:

SIGNATURE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ NAME:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ADDRESS/CITY/ZIP: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

PHONE:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DATE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

***THANK YOU IN ADVANCE FOR YOUR PROMPT ATTENTION TO THIS MATTER!***