IMP Physicians
The Future of Healthcare

Authorization for Use or Disclosure of Protected Health Information

☐ 1168 Alliance Rd.	☐ 1207 W. State St., Ste. N	☐ 4080 Holiday St. NW
Minerva, OH 44657	Alliance, OH 44601	Canton, OH 44718
330-868-3711	330-821-3244	330-492-8117

Central Fax Number (330) 868-5782

I, _____, (date of birth)_____, hereby authorize Internal Medicine Physicians and my provider:

☐ Mark Hostettler, MD ☐ David Kimbell, MD ☐ Pamela Rodocoy, MD
☐ Jacquelyn Dennis, APRN,CNP ☐ Matt Gooch, APRN,CNP ☐ Quinn M. Repp, PA-C

☐ to **disclose** the following personal health information(PHI) to: (name and address of party to whom PHI is being disclosed)

_____

☐ to **request** my personal health information (PHI) from: (name and address of party from whom PHI is being requested)

_____

Please send:
☐ Office visit notes from the past 12 months; most recent lab and most recent results of all diagnostic tests
☐ Other _____

Please note: we cannot accept medical records on CD/flash drive; please fax to (330) 868-5782.

The minimum necessary of the above checked items of PHI being released and/or received is being used or disclosed for the following purpose:_____

I, the undersigned, authorize IMP to release health information as indicated/described above. I understand and acknowledge that the requested health information may contain information regarding physical and mental illness, HIV test results or diagnosis, treatment of AIDS/AIDS-related conditions, and/or alcohol/drug abuse. This authorization does not include permission to release outpatient Psychotherapy Notes as defined below. *Release of Psychotherapy Notes requires a separate authorization.

This authorization shall be in force and effect until (specify date or event that relates to the patient or the purpose of the use or disclosure) _____ at which time this authorization to use or disclose this PHI expires.

I understand that I have the right to revoke this authorization in writing at any time by ending such written notification to Administrator at Internal Medicine Physicians. I understand that a revocation is not effective to the extent that Internal Medicine Physicians has relied on the use or disclosure of the PHI.

I understand that information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law.
Internal Medicine Physicians will not condition my treatment, payment, enrollment in a health plan or eligibility for benefits (if applicable) on whether I provide authorization for the requested use or disclosure.
I understand that I have the right to:

- Inspect or copy the PHI to be used or disclosed as permitted under federal law (or state law to the extent the state law provides greater access rights.)
- Refuse to sign this authorization.
- Receive a signed copy of this authorization upon request.

_____ _____
Printed Name of Patient or Personal Representative | Description of Personal Representative Authority

_____ _____
Signature of Patient or Personal Representative | Date

_____ _____
Witness | Date