iHealth
Infinite Health Collaborative

Internal Use Only | Account #_____
Pickup Instructions_____

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

Please complete all sections legibly. Incomplete forms may result in delay or denial of this request.

1. PATIENT INFORMATION	PATIENT NAME:	
	DOB: / /	PREVIOUS NAME(S):
2. RELEASE MY RECORDS FROM	FACILITY NAME:	
	DR. NAME:	
3. SEND MY RECORDS TO	NAME:	ATTN TO:
	ADDRESS:	
	CITY:	STATE: ZIP:
	PHONE:	FAX (For Continuing Care ONLY):
	UPCOMING APPT DATE: ___ / ___ / _____	
4. TYPES OF RECORDS	BODY PART:	
	DATE(S) OF SERVICE:	
	☐ Lab Results ☐ Pathology Reports ☐ All Health Records (not including billing or imaging) ☐ Immunizations ☐ Operative Notes ☐ Other_____	
5. VERBAL DISCLOSURE	For verbal disclosure, check here: _____	
	"Verbal disclosure" authorizes Infinite Health Collaborative to discuss my care with the person(s) indicated in this section:	
6. REASON FOR REQUEST	☐ Personal Use ☐ Insurance ☐ Workers Compensation ☐ Disability ☐ Legal ☐ Continuing Care	
	Do you need patient photos? ☐ Yes ☐ No	
7. RETURN COMPLETED FORMS TO:	**MAIL TO:** Infinite Health Collaborative 4200 Dahlberg Drive, Suite 300 Golden Valley, MN 55422	**FAX TO:** 470-795-7180 **DROP OFF:** At Infinite Health Collaborative
	* Records will be mailed to the person(s) identified in section 3. Please allow up to 2 weeks for processing.	
8. I UNDERSTAND THAT BY SIGNING THE BELOW:	• I may revoke this authorization at any time by notifying the facility identified above in writing. • By authorizing the release of my protected health information, the health information is no longer protected and has the potential to be re-disclosed. • There may be a fee for release of this information and I may be responsible for that fee. • I am authorizing the release of my personal protected health information to and from the entities I've indicted above • Treatment will not be denied to me if I do not sign this form. • This authorization will expire one year from the date I sign on this form. SIGNATURE: _____ DATE: _____ PRINT NAME: _____ *If this form is signed by someone other than the patient, legal documentation showing guardianship or authorization must be on file or presented with this form.	

Electronic or Typed Signatures cannot be accepted