

**Inter Valley Health Plan
Toll Free (800) 251-8191, TTY (800) 505-7150
Medical Release Form**

This authorization should be given to one of the providers listed below as soon as possible prior to the upcoming need for the records. Processing the Medical Release Form often takes several weeks.

Patient Name (please print)		Date of Birth	ID Number
Patient Address		City/State/Zip Code	
Give other name patient received treatment under			
I hereby authorize (those named below)		to furnish to (those named below)	
Name of Hospital or Provider of Health Care		Name	
Address		Address	
City/State/Zip Code		City/State/Zip Code	
The following information from my records in your file:			
<input type="checkbox"/> Send Entire File	Date of records:		
<input type="checkbox"/> Consultations	<input type="checkbox"/> History and Physical Exam	<input type="checkbox"/> Operative and Pathology Reports	
<input type="checkbox"/> Discharge Summaries	<input type="checkbox"/> Immunizations	<input type="checkbox"/> Progress Notes	
<input type="checkbox"/> ER/Urgent Care	<input type="checkbox"/> Lab and X-ray Reports	<input type="checkbox"/> Other	
The use of my records is to be limited to the following (check one):			
<input type="checkbox"/> Healthcare		<input type="checkbox"/> Liability	
<input type="checkbox"/> Workers Compensation (accident date)		<input type="checkbox"/> Other _____	
DURATION: This authorization shall become effective immediately and shall remain in effect:			
<input type="checkbox"/> until date specified _____			
<input type="checkbox"/> as long as necessary for the requestor to fulfill the obligations required.			
I may revoke this authorization at any time in writing, signed by me or on my behalf and delivered to one of the providers listed above.			
AUTHORIZATION: I, the undersigned, being (check one)			
<input type="checkbox"/> the above-named patient		<input type="checkbox"/> the legal representative	
do hereby authorize and request that the above-named provider of health care release to the person or entity named above, subject to the limitations and uses stated herein, the medical information requested above.			

I further understand that I have the right to receive a copy of this authorization upon my request. The provider may charge fees for medical record copies.

Signature	Print Name	Date
WITNESS	Address (if other than that of patient)City/State/Zip	

I hereby further authorize the release of the following confidential information which is protected under the California Welfare and Institutions Code, Section 5328. This authorization shall be valid until the date stated above.

- Psychiatric Records
 Substance Abuse
 HIV/AIDS

Signature of patient/spouse/patient's representative	Date
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If signed by other than Patient, indicate relationship

Witness