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:

☐ Send Entire File	Date of records:	
☐ Consultations	☐ History and Physical Exam	☐ Operative and Pathology Reports
☐ Discharge Summaries	☐ Immunizations	☐ Progress Notes
☐ ER/Urgent Care	☐ Lab and X-ray Reports	☐ Other

The use of my records is to be limited to the following (check one):

☐ Healthcare ☐ Liability
☐ Workers Compensation (accident date) ☐ Other___________________________

DURATION: This authorization shall become effective immediately and shall remain in effect:

☐ until date specified_______________________
☐ 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)

☐ the above-named patient ☐ 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

____ __________________________
If signed by other than Patient, indicate relationship Witness