# Transfer of Records Request

I, _____ DOB: _____, hereby authorize IM Health to obtain my records from:

Doctor/Facility Name: _____

_____

Street City State Zip

Phone Number: _____ Fax Number: _____

Checking the following items grants specific permission for the designated information to be released or obtained from the above named party:

€ Immunization records

€ Physical Exam – **within the last year only**

€ Labs – **within the last year only**

€ Colonoscopy

€ Diagnostic Imaging to include Mammogram, EKG, X-rays, MRIs

€ Specialist Consults

I understand that I may revoke this authorization at any time in writing. If not sooner revoked, this authorization shall be valid for the period of time necessary for continuing care, the processing of claims or the completion of peer review. By signing this form, I relieve IM Health of any responsibility regarding previous records obtained from any other medical practices.

Signature of Patient/Guardian: _____ Date: _____

**PLEASE DO NOT FAX IF RECORDS EXCEED 25 PAGES; MAIL TO OUR OFFICE AT THE ADDRESS BELOW.**

372 W LANCASTER AVE
WAYNE PA 19087

im HEALTH