# 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:

☐ All documents including labs, studies, correspondence and physician notes

☐ Substance abuse information

☐ Psychiatric/mental illness information

☐ HIV/ARC/AIDS information

☐ Immunization records

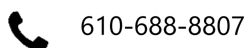
I understand that I may revoke this authorization at any time in writing. If not sooner revoked, this authorization shall be valid for the period of time necessary for continuing care, the processing of claims or the completion of peer review. By signing this form, I relieve IM Health of any responsibility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

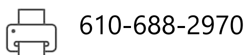
Signature of Patient/Guardian: _________________________________________ Date: _________________

## ATTENTION TRANSFERRING FACILITY

Please send any immunizations on file if available as well as last physical exam. **Limit to pertinent testing only.**

*Do **NOT** fax more than 25 pages. Please mail records if over 25 pages.

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