Innovative Healthcare Physicians

Your OBGYN Healthcare Partner

Authorization for Release of Medical Records To IHP

Patient Information			
Patient Name		Date of Birth	Social Security Number
Address			
City	State	Zip	Phone
Release From : (Name of the Physician or Facility releasing information)			

I authorize release of my Medical Record from

Physician/ facility			
Address: Fax			
City	State	Zip	Phone

Release To : (Name of the Physician or Facility receiving information)

Innovative Healthcare Physicians PC
225 Broadway Suite 901
New York, NY 10007
Tel 212 393 9400 Fax 212 393 9405

Please release the following (check all that apply)

	Yes	No		Yes	No
Recent H&P			LAST THREE VISITS		
LAB REPORTS			X-RAY REPORTS		
HIV/HTLV/AIDS test results			HOSPITAL REPORTS		
OTHER :			OTHER :		

Consent

I authorize the release of all information indicated, and I am aware that the records released may contain information relating to psychiatric or psychological testing, physical abuse, or drug and alcohol abuse. I understand that I may be charged for copies provides.

_____ _____

Name & Signature of patient, parent, guardian, conservator, or patient representative (please circle) Date