

## Patient Request Form

Please Submit This Form To Us Immediately  
Standard Turnaround time is 4-10 business days.

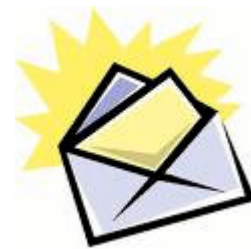
If you have any questions, please call us at (510) 490-6211



Fax #  
1-877-410-5522



Mail: 46540 Fremont Blvd Suite 514  
Fremont, CA 94538



Email:  
APS@imsparmed.com

### Service Charge:

\$25.00 ( 1-150 pages) \*(Does not include Taxes & Shipping)

I Agree (Please Check):

- Additional \$10 will be charged for records over 150 pages
- If the facility requires a Retrieval Fee it will be added to our service charge

### Shipping Method:

- Standard Mail (5.00)
- DHL Ground (10.00)
- Email (5.00) Faster Turnaround Time
- Email: \_\_\_\_\_
- Access via the website (5.00) Fastest

### Payment Information:

Name on Credit Card: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Credit Card #: \_\_\_\_\_

Expiration Date: \_\_\_\_/\_\_\_\_

Visa  Mastercard  AMEX  Discover

Payments made by check will delay request 5 business days.



# Authorization to Release Patient Health Information

(To Complete Your Request Please Sign and Send Form to IMS)

Fax to IMS at 1-877-410-5522

Email to IMS: [APS@imsparamed.com](mailto:APS@imsparamed.com)

### Patient Information:

First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_

DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_ Phone# \_\_\_\_\_

### Doctor / Facility Requests Records From:

Name: \_\_\_\_\_ Phone#: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

### Ship Records to:

Name: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

By my signature below, I terminate any agreements made or implied to restrict my protected health information. I instruct the medical facility named above, to release any and all information relating to my confinements for physical and mental conditions, use of drugs or alcohol, and all communicable diseases including HIV or AIDS. I authorize the release information except where initialized below. *Please initial the information you **do not** want released.*

Alcohol / Drug Abuse

AIDS / HIV

Mental Health

Other: \_\_\_\_\_

The other information that will be disclosed to IMS will be for a personal record of my health history. I understand that the requestor may not lawfully further use or disclose the health information provided unless disclosure is specially required or permitted by law.

This authorization may be revoked in writing by the undersigned at any time prior to the release of information from the disclosing party. The written revocation will not affect any actions taken prior to the receipt of the revocation.

I further understand that treatment, payment, enrollment or eligibility for benefits will conditioned on my providing or refusing to provide this authorization. A copy of this authorization is as valid as original. And finally, I agree to pay all fees associated with the act of locating, reviewing, copying and mailing requested information. I have received a copy of this authorization.

Signature: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_