



Industrial Medical Associates, P.C.

- 961 Canal St., Syracuse, NY 13210 (315) 478-1977 Fax (315) 475-2909
- 151 Lawrence Road E, North Syracuse, NY 13212 (315) 458-1335 Fax (315) 458-1738

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

Patient Name: _____

Social Security #: _____ DOB: _____

I authorize Industrial Medical Associates, P.C. (IMA) to release any and all health care records, reports or information with respect to my physical or mental condition and/or treatment of me, as IMA deems necessary and relevant to my work status to:

Company, Physician, Patient, Other

Address

City, State, Zip Code

Fax Number

This authorization shall remain in force for one year or until _____ (expiration date), or for a reasonable time to accomplish the purpose of which it was given. I understand that I may revoke this authorization at any time by notifying the providing organization in writing, and it will be effective on the date notified except to the extent action has already been taken in reliance upon it. I understand the revocation excludes by law requests by regulatory bodies (Workers Compensation, DOT, OSHA).

Once health information is disclosed pursuant to this authorization, it may be re-disclosed and may no longer be protected by privacy laws.

Patient Signature (If under 18, Signature of Parent or Legal Guardian)

Date

Witness