

AUTHORIZATION TO RELEASE HEALTH INFORMATION

I, _____, hereby authorize Nashville Healthcare Diagnostic Imaging to disclose health information regarding the following patient

Patient Name	_____	Date of Birth	_____
Address:	_____	Phone :	_____
	_____	Medical Record #	_____

1. The information is to be disclosed to the following persons or organizations:

Name: _____

Address _____

2. Purpose. The purpose of the use or disclosure is:

At the request of the patient Other _____

3. Information to be Disclosed. The information to be disclosed includes only those items checked below, with respect to the services provided on the or around _____(insert dates)

The following medical records:

Radiology Images

Radiology Report(s)

4. Revocation. I understand that I may revoke this authorization at any time by sending a written notice to Nashville Healthcare Diagnostic Imaging. However, the revocation will not have any effect on any uses or disclosures Nashville Healthcare Diagnostic Imaging may have made before the revocation was received

5. Expiration. I understand that unless I revoke the authorization earlier, this authorization will automatically expire six (6) calendar months after the date this authorzaion is signed.

6. Redisclosure. I understand that information used or disclosed in accordance with this authorization may no longer be protected by federal law, and could be redisclosed by the receiving party.

7. Refusal to Sign. I understand that I may refuse to sign this Authorization and that Nashville Healthcare Diagnostic Imaging will no condition treatment on whether I sign this Authorization.

8. Certification. I certify that I am (check whichever applies):

the patient, and the identification that I have provided is true and correct

the patient's authorized representative, and that the identification and proof of authority that I have provided are true and correct.

Signature: _____	Witness: _____
Print Name: _____	Print Name: _____
Date _____	Date: _____

For NHDI Use Only:

Date Received: _____

Expiration Date: _____

How was identity verified?: _____

Copy made?: Yes NO

How was authority verified?: _____

Copy made?: Yes NO

By: _____

Title: _____

Date: _____