



Authorization for Release of Confidential Health Information



Part 1: Patient Information

Name: _____ Date of Birth: _____ Phone: _____

Street Address: _____ City, State, Zip: _____

Part 2: Select which organization(s) are included in this release

- Advanced Imaging Center, LLC
- Metro MRI Center Limited Partnership
- Mississippi Valley MRI

Part 3: Authorized Recipient (person or entity)

Name of person or entity: _____ Phone: _____

Street Address: _____ City, State, Zip: _____

Relationship to Patient: _____

Reason for release (*ex: Continued care, consultation, insurance, personal reasons, etc.*): _____

Part 4: Information authorized to be disclosed

Select at least one option:

- To be involved in my care, and assist with or be present for scheduling, exam preparation, and examination as permitted by staff.
- To have access to my medical records as indicated below:
 - The complete medical record excluding treatment records for the following unless specifically authorized:
 - Mental health
 - Alcoholism
 - Drug abuse
 - HIV/AIDS
 - Only the portions of my records as selected below:
 - Radiology report(s)
 - Radiology image(s) & available report(s)

Select ONLY one option:

Released information may be limited to a single date of service, a date range, or any and all dates. Select one of the following options and add in the dates when appropriate.

- Any and all dates of service.
- Only for the date of service of _____.
- For services rendered between the date range of _____ to _____.

Continue to signature —>



Part 5: Signed Authorization

Select one option:

I authorize the healthcare provider(s) listed above to use and disclose the protected health information described in this release:

- from the date of this signed document until the date of _____. As of this date, access will no longer be granted to the person/entity unless a new release is submitted.
- for a period of one year from the date signed (below).

- ✓ I understand this authorization does not include billing records and a separate release would be required for such records.
- ✓ I understand I may revoke this authorization in writing by submitting my request to the facility. Revoking the authorization prevents any further disclosures of my information except where otherwise permitted by the facility’s privacy practices which are available in office and online. Request to revoke authorization only applies to future disclosures based on the date of receipt of the request to revoke.
- ✓ I release the above named facility(ies) from liability arising from the release of this information to such persons/entities, provided the release from the facility(ies) is in accordance with applicable law. I understand that records disclosed to a third party may no longer be protected by law to prevent further disclosure by the recipient. The above named facility(ies) are not responsible for disclosures made by the recipient of the authorized information.
- ✓ I understand I have the right to access a copy of patient records that are disclosed and a list of who received such records.
- ✓ I understand the facility may not condition treatment on whether or not an authorization is signed, except when the provision of health care is solely for the purpose of creating protected health information for disclosure to a third party.
- ✓ I have read the information and understand the terms of this authorization. I have had the opportunity to ask questions about the use and disclosure of my information.

Patient Name: _____

Relationship

Requestor Name: _____

to Patient: _____

Printed name

Self, parent, etc.

Requestor Signature: _____

Date: _____