



**Full-Service, All Digital Imaging Network**

**Authorization To Release Protected Health Information**

**FAX TO MEDICAL RECORDS FAX: (909) 786-4394**

**PATIENT & REQUESTOR INFORMATION**

Patient Name: \_\_\_\_\_ MRN (Office Use): \_\_\_\_\_  
 Date of Birth: \_\_\_\_\_ Patient Phone#: \_\_\_\_\_  
 Name of Person or Physician Requesting Records \_\_\_\_\_

As required by the Health Information Portability and Accountability Act of 1996, you have a right to request the opportunity to inspect and/or copy health information that pertains to you. A "Health Care Provider" will evaluate your request and will either grant it or explain the reason why the request will not be granted. In the event that your inspection/copy request is not granted, you may request that the decision be reviewed by our facility's Privacy Officer.

I, \_\_\_\_\_, give authorization to release the following diagnostic radiology records performed at Centrelake Imaging only: **[SELECT ONE]**

- From Dates of Service \_\_\_/\_\_\_/\_\_\_ to \_\_\_/\_\_\_/\_\_\_
- Date of service ONLY: \_\_\_/\_\_\_/\_\_\_
- All** available records to date

**Expiration date of this consent:** \_\_\_/\_\_\_/\_\_\_ (If no dates indicated, this consent extends indefinitely)

The above listed records should be released to the following individual(s) ONLY:

Authorized Individual's Legal Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
 Authorized Individual's Legal Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

I understand that after the custodian of records discloses my health information, it may no longer be protected by federal and/or state privacy laws. I understand that this authorization is voluntary and it gives the authorized individual permission to accept my records for medical reasons only. Records will be released to this authorized individual only after proper identification (government issued ID w/ photograph) has been verified. I understand that this authorization may be revoked in writing at any time, except to the extent that action was taken in reliance on the authorization.

**Signature of Patient/Guardian:** \_\_\_\_\_ **Date:** \_\_\_\_\_ **Telephone Number:** \_\_\_\_\_

Office Staff Only:

Patient/Authorized Individual Identified Was Verified by Viewing Photo ID  YES  NO

Medical Records prepared and verified by: \_\_\_\_\_