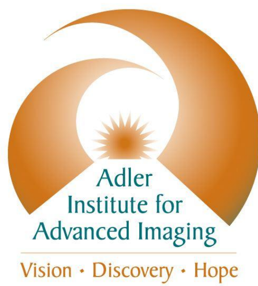

Authorization for Release of Patient Health Information

Date: ____/____/____

Patient's Name: ____________________________________ D.O.B.: ____/____/____

Medical Record Number: ___________________

Name of Requestor: ______________________________ Phone: (____) ____-_____

I hereby authorize the ______________________________to release to Adler institute for Advanced Imaging:

Specific information to be disclosed:

☐ ***Report(s)***

Date(s): ______________ Procedure(s): ____________________________________

______________ ____________________________________

______________ ____________________________________

☐ ***Film(s)***

Date(s): ______________ Procedure(s): ____________________________________

______________ ____________________________________

______________ ____________________________________

☐ Duplicate files given to patient.

This health information is needed for:

☐ Continuing Medical Care ☐ Personal Use ☐ Other _______________

☐ Legal Reasons ☐ Transfer

☐ Social Security/Disability ☐ Insurance

I understand that the information in my health record may include information about my history, diagnoses and/or treatment. I authorize the disclosure of this specific information listed above. I understand that once the above information is disclosed, it may be re-disclosed by the recipient and federal privacy laws or regulations may not protect information. I recognize these films are the property of ______________________ and they are legally responsible for this permanent record. By signing this form, I agree to return original films in 30 days. Your signature allows us to release medical information to the parties designated above for one year.

Patient/Recipients Name (print) Patient/Recipients Name (signature)

Phone Number

Witness