Authorization for Release of Confidential Health Information

I, _____ Hereby authorize (check only those that apply) to release my information to myself or the entity listed below

(Name of Patient or Authorized Agent)

☐ **Advanced Radiology, S.C.**
☐ **Metro MRI Center Limited Partnership**
☐ **Advanced Imaging Center, LLC**
☐ **Clinton Imaging Services**

(Patient Name)_____

(Street Address)_____

(City, State, ZIP)_____

(Date of Birth)_____ **(Phone)** _____

All portions of this form must be completed or it is rendered invalid.

(Date of Injury)_____

(Claim Number)_____

(Name)_____

(Street Address) _____

(City, State, ZIP)_____

Should you wish to release your records to an outside entity you must list the name, address, date of injury, and the claim number.

I request release of the information from (date) _____ **to (date)** _____

☐ **The medical record** (*excluding* mental health, alcoholism, drug abuse and HIV/AIDS treatment records).
To be disclosed, the following item(s) must be specifically checked and initialed by patient:
☐ Mental Health Treatment Record(s) ____ ☐ Alcoholism Treatment Record(s) ____
☐ Drug Abuse Treatment Records(s) ____ ☐ HIV / AIDS Record(s) ____

☐ **Billing Statement(s)** ☐ **Radiology Report(s)** ☐ **Other** _____

The purpose(s) of the authorization is: _____

- I understand that I have the right to inspect and copy the information I have authorized to be disclosed by this authorization. In the event I refuse to authorize the release of the above described information, I understand that it will not be disclosed, except as provided by law.
- I understand that the practice may not condition treatment on whether I sign this authorization, except when the provision of health care is solely for the purpose of creating protected health information for disclosure to a third party.
- I release the practice/centers named above from any liability arising from the release of this information to such persons and/or agencies, provided the said release of information is done in accordance with applicable law.
- I understand that this authorization is valid until it expires, unless revoked prior to that time.
- I understand that I may revoke this authorization at any time by giving written notice to the facility of my desire to do so. I also understand that I will not be able to revoke this authorization in cases where the practice/facility has already relied on it to use or disclose my health information. Absent such written revocation, this Authorization for Release of Confidential Health Information will terminate on (date)_____ or will not exceed one year from date of signature.
- I understand that information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by law.
- I have read and understood the terms of this Authorization and I have had the opportunity to ask questions about the use and disclosure of my health information.

Signed: _____Date:_____

If you are not the patient, please specify your relationship to the patient:_____