The Imaging Center

Main 970-282-2900 • Scheduling 970-282-2912 • Fax 970-282-9800
Harmony Campus: 2127 E Harmony Rd, Ste 130, Fort Collins, CO 80528
Loveland Campus: 2500 Rocky Mountain Avenue, Suite 150, Loveland, CO 80538

PATIENT AUTHORIZATION FOR THE RELEASE OF PROTECTED HEALTH INFORMATION (PHI)

Patient Name: _____

Birth Date: ____/____/_____ Email: _____ Phone #: _____

I hereby authorize The Imaging Center to release the Protected Health Information to:

Name: _____ Fax #: _____

Address: _____ Apt, Ste, etc. _____

City: _____ State: _____ Zip: _____

I authorize the release of the following Protected Health Information:

Exam: _____ Date of Service: _____

Exam: _____ Date of Service: _____

Exam: _____ Date of Service: _____

This Protected Health Information is to be used for the following purposes:

□ Continuity of Care □ Self Use □ Other

Please choose **ONE** of the following formats for requested information:

□ CD of Images & Written Report □ Copy of Written Report (paper copy) □ CD of Images (does not include written report)

I have the right to revoke this authorization in writing at any time, except that it cannot be revoked as to the protected health information that had been previously released in reliance on this document. I also understand that my written revocation will not affect the ability of The Imaging Center to continue to use or disclose my protected health information to the extent it has already acted in reliance on this authorization or for treatment, payment or health care operations.

I understand that a refusal to sign this form will not result in a denial of health care by The Imaging Center or any other health care provider and that this release has not been coerced by The Imaging Center or any of its business associates.

I understand that my health information disclosed according to this authorization will no longer be protected by the federal privacy law (known as "HIPAA") and the recipient of the information may potentially re-disclose it.

The statements made in this authorization are binding, controlling, and I understand that they take precedence over statements made in The Imaging Center's Notice of Privacy Practices.

_____

Signature of Patient or Personal Representative Date

_____

Relationship to Patient (if signed by Personal Representative)

Office Use Only:

□ Pt took CD of Images Request Taken By: _____ MRN: _____

OR

□ Pt took Written Report Initials of Person Burning CD: UNO:_____

□ Mail □ Email _____

□ Pick up – Date Needed: _____ □ CD Checked and Complete

□ Report CC'd to Office: _____

**** AUTHORIZATION EXPIRES ONE YEAR FROM THE DATE SIGNED****

Revised 7/2017