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: _____
(PLEASE PRINT)

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

Name: _____ Fax #: _____

Address: _____ Apt, Ste, etc. _____

City: _____ State: _____ Zip: _____

Report CC'd to Office: _____

Exam: _____ Date of Service: _____

Exam: _____ Date of Service: _____

Exam: _____ Date of Service: _____

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

□ PowerShare (Cloud) □ Flash Drive Only □ CD Only

□ Written Report Only □ Flash Drive & Written Report □ CD & 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: Request Taken By:_____ MRN: _____

□ PowerShare UNO: _____

□ Pt took Flash Drive Initials of Person Burning Images/PowerShare _____

□ Pt took CD □ FD/CD Checked and Complete

□ Pt took Written Report PLACE LABEL HERE

□ Mail □ Email (Report)

□ Pick up – Date Needed: _____

**** AUTHORIZATION EXPIRES ONE YEAR FROM THE DATE SIGNED**** **Revised 5/2019**