Authorization for Release of Protected Health Information

Name of Physician or Facility: ____________________

Address ____________________ City: ____________________

State: __________ Zip: __________ Phone: ____________________ Fax: ____________________

Patient Name: ____________________ Birth Date: ____________________

Birth Date: __________ Social Security # (last 4 digits only): __________ Telephone: ____________________

Address ____________________ City: ____________________ State: ______ Zip: ________

I hereby authorize the above-referenced entity to release the medical information about me indicated below to the following recipient:

Recipient Name: ____________________

Address ____________________ City: ____________________ State: ______ Zip: ________

Phone: ____________________ Fax: ____________________

FOR THE FOLLOWING PURPOSE: ☐ Continued Care*: ____________________

***DATES OF SERVICE NEEDED**

☐ All Dates of Service ☐ Last Visit Only ☐ From: ____________________ To: ____________________

MEDICAL INFORMATION TO BE RELEASED:

☐ Complete Record *(no films)* ☐ Emergency Department Record ☐ History & Physical ☐ EKG Reports *(no films)*

☐ Cardiovascular Reports ☐ Discharge Summary ☐ Radiology Reports *(no films)*

☐ Pathology Reports ☐ Consult Report ☐ Mammography Reports *(no films)*

☐ Anesthesia Record ☐ Operative/Procedure Report ☐ Laboratory Reports

☐ Other: ____________________

I am aware that such records may include information relating to the diagnosis, treatment and/or examination of alcohol and drug use; mental health (psychiatry/psychology/psychotherapy); HIV (Human Immunodeficiency Virus) and AIDS (Acquired Immune Deficiency Syndrome); and sexually transmissible diseases, and I specifically authorize the release of such information.

I understand that this Authorization will remain in effect for one (1) year, but I may revoke it any time in writing. I further understand that any such revocation will not apply to any information already released under this Authorization. I acknowledge that I am under no obligation to sign this Authorization and that my ability to obtain treatment from Optimal Imaging Sacred Heart and its affiliates will not depend in any way on whether I sign the Authorization or not.

Federal and State laws prohibit the Recipient of this information from using it for other than the stated purpose. The law also prohibits recipients from making any further disclosure of this information without the specific written consent of the patient. However, I understand that Optimal Imaging Sacred Heart and its affiliates cannot guarantee that recipients of the information will not use or re-disclose it contrary to such legal prohibitions, and the information may no longer by protected by privacy laws once i t has been so used or re -disclosed.

The law also prohibits the disclosure of mental health records to certain individuals in some circumstances, which may include patients and their family members. I hereby release Optimal Imaging Sacred Heart and its affiliates, and their contractors and employees, from any and all liability that may arise from the release of information as I have directed. I have read and understand this authorization. I hereby authorize the release of the above-requested medial information about me.

I have read and understand this authorization. I hereby authorize the release of the above-requested medial information about me.

____________________ ____________________

Signature of Patient **Signature of Patient's Representative**

____________________ ____________________

Date **Representative 's Name / Relationship to Patient**

Revised 08.10.2017