

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 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: _____

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

PowerShare (Cloud) CD of Images & Written Report Written Report CD of Images (without 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:

PowerShare

Request Taken By: _____

MRN: _____

Pt took CD of Images

UNO: _____

Pt took Written Report

Initials of Person Burning CD/PowerShare: _____

Mail Email

Pick up – Date Needed: _____

CD Checked and Complete

Report CC'd to Office: _____

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