AUTHORIZATION FOR DISCLOSURE OF PHI/RADIOLOGY FILMS

Completion of this document authorizes the disclosure and / or use of individually identifiable health information consistent with state and federal laws concerning the privacy of such information.
Print in ink – Failure to provide *all* information requested may invalidate this authorization.

Use and Disclosure of Radiology Films/Protected Health Information

I authorize *Magan Medical Clinic, Inc.* to:

☐ Provide Records to:

☐ Provide films (original/copy) to: ☐ Include Report

Individual/Agency Name: _____ ***Phone ( )*** _____ ☐ ***Mail*** ☐ ***Pick-up***

Address _____ ***City*** _____ ***State*** _____ ***Zip Code*** _____

☐ Obtain Records from:

☐ Obtain Films from:

☐ Include report

Individual/Agency Name: _____ ***Phone ( )*** _____ ☐ ***Mail*** ☐ ***Pick-up***

Address _____ ***City*** _____ ***State*** _____ ***Zip Code*** _____

☐ Review of Records: *Must set up date with R.O.I. desk.*
Appointment date: _____ Time _____ Technician _____

Information to be Released

☐ All Records
☐ Progress Notes
☐ Immunization Record
☐ Test Results For: _____ Dates of: _____
☐ Other, specify _____ Dates of: _____

I specifically authorize release of the following information: _____
☐ HIV test results

Radiology Films To Be Released

☐ Type(s) of service: _____ Date: _____

I understand that my original films are being loaned to me. Magan Medical Clinic, Inc. is not to be held responsible/liable for loss, damage, or theft that may occur while on loan to me or another facility. I also understand that by signing below I am accepting full responsibility for films and seeing that they are returned to Magan in their original condition.

Purpose

Purpose / Reason records are to be disclosed:

☐ Continued Care ☐ Personal Use ☐ Insurance ☐ Other, Specify _____

COMPLETE OTHER SIDE AND SIGN

Unless otherwise revoked, this authorization will expire on the following date, event or condition _____ _____. If I fail to specify an expiration date, event or condition, this authorization will expire 90 days from the date of signature. Signing this form is voluntary. I understand I have the right to revoke this authorization and the right to inspect or get a copy of the material to be disclosed. **See reverse side for details on disclosure of information and my rights.** I have read both sides of this form and voluntarily authorize and request the disclosure above. I authorize use of a copy (including facsimile copy) of this form for disclosure of the information described above.

Patient Name: _____ SSN#_____
Last First M.I.

Birth Date:_____ Phone Number ( )_____

Signature, Patient or Legal Representative:_____Date:_____

_____ _____
Relationship to patient (if signed by Legal Representative) Witness

Important Information Regarding My Rights

Voluntary
I understand authorizing the disclosure of the information identified on this authorization is voluntary. I need not sign this form to ensure healthcare treatment.

Right to Revoke
I understand that I have the right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the Health Information Services Department. The revocation will take effect upon receipt. I understand that the revocation will not apply to information that has already been released in response to the authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.

Right to Inspect
I understand that I may inspect or obtain a copy of the information to be used or disclosed, as provided in CFR 164.524 and that I have a right to a copy of this form.

Re-disclosure
I understand that any disclosure of information carries with it the potential for an unauthorized redisclosure and the information may not be protected by federal confidentiality rules.

APPT. LABEL (REQUIRED ON PAGE 1 ONLY)

Revised [07/2009]
Form A110a