HEALTH RECORD RELEASE AUTHORIZATION

CHEYENNE RADIOLOGY

Last Name: _____ First Name:_____

Address: _____

City, State, Zip: _____

Phone:_____ Date of Birth: _____

RECORDS RELEASED TO:

Name *(i.e. Health Facility, Insurance Co, Physician, Self., Lawyer)*:

_____

Address: _____

City, State, Zip: _____

Phone:_____Fax: _____

These records are needed by: _____

INFORMATION TO BE RELEASED: *(Check all applicable categories)*

☐ Report ☐ Films *(i.e. xrays, mammograms, US, CT, MR)*

☐ CD Exam Type: _____ Date: _____

Exam Type: _____ Date: _____

Exam Type: _____ Date: _____

Exam Type: _____ Date: _____

PURPOSE OR NEED FOR DISCLOSURE: *(Check applicable categories)*

☐ Further Health Care ☐ Legal

☐ Insurance/Claims ☐ Personal

☐ Application for Insurance

This authorization will remain in effect until this request is processed, unless you specify this authorization will be effective for an additional time period.

I authorize release of my health records in accordance with the specification listed above.
A photocopy of this consent shall be valid as the original.

Signature of patient or Guardian: _____

Date: _____ Release Date:_____ ☐ Report ☐ Films ☐ CD

☐ Picked up Completed by Initials_____

HEALTH RECORD RELEASE AUTHORIZATION

I understand I may revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing. I understand that the revocation will not apply to information that has already been released in response to this 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.

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand that I may inspect or obtain a copy of the information to be used or disclosed. 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. If I have questions about disclosure of my health information, I can contact the authorized individual or organization making disclosure.

I have read the above forgoing Authorization for Release of Information and do herby acknowledge that I am familiar with and fully understand the terms and conditions of this authorization. Initial____

Authorized Representative: _____ Phone Number: _____

Address: _____