MRN: _____
(Office Use)

children's health℠
Imaging Center

Patient Records Release and Authorization for Use or Disclosure of Protected Health Information

By signing this form, I authorize Children's Health Imaging to release confidential health information about me by releasing a copy of my medical records Records include: radiology reports, radiology images, referring physician order/demographic sheet, progress notes, history /physical, consultation notes, treatments, test results/lab work, pharmacy prescriptions, billing records (including statements, insurance claim forms, insurance information, itemized bills), and records received by other medical providers

Patient Name: _____ **Date of Birth**: _____
(first) (m. initial) (last)

Patient Address: _____ **Phone**: _____
(street address) (city) (state) (zip code)

Request to release to patient:
I hereby authorize and request Children's Health Imaging to release all Medical Records, pertaining to me, directly to my email and/or fax

Email: _____ **Fax:** _____

Request to release to authorized persons:
I hereby authorize Children's Health Imaging to release all Medical Records, pertaining to me, to the following person(s):

Primary person name: _____ Relationship: _____

Email Address: _____

Fax Number: _____

Secondary person name: _____ Relationship: _____

Email Address: _____

Fax Number: _____

Request to release to Additional Physician:
Note: Your Referring Physician will receive a copy of your report and images. You do not need to request a copy be sent to the Physician that sent you in for your images.

Physician Name/Entity: _____ Phone: _____

Email Address: _____

Fax Number: _____

I UNDERSTAND THAT:

- This form is voluntary, I may refuse to fill out/sign this form. Refusal to sign will not affect my ability to obtain treatment
- This form can be changed and/or revoked/withdrawn at any time
- Once my Medical Record has been disclosed as requested, it may no longer be protected by federal and state privacy laws, and could be re-disclosed by the person(s) receiving it
- That all fees for additional images are due before any images can be released and I agree to pay this fee.

By signing below, I represent and warrant that I have authority to sign this document and authorize the use of disclosure of protected health information and that there are no claims or orders pending or in effect that would prohibit, limit, or otherwise restrict my ability to authorize the use or disclosure of this protected health information.

Parent/Guardian Signature: _____ Date: _____

Parent/Guardian Print Name: _____ Relationship to Patient: _____