

**Authorization for Release of Patient Identifiable Health Information**

Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Patient's Name: \_\_\_\_\_ D.O.B.: \_\_\_\_/\_\_\_\_/\_\_\_\_

Medical Record Number: \_\_\_\_\_

Name of Requestor: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_-\_\_\_\_

I hereby authorize \_\_\_\_\_ to release to:

- |                                    |  |  |
|------------------------------------|--|--|
| <input type="checkbox"/> Physician | <input type="checkbox"/> Auto Insurance                  | <input type="checkbox"/> Guardian or power of attorney |
| <input type="checkbox"/> Hospital  | <input type="checkbox"/> Workman Compensation            | <input type="checkbox"/> Other _____                   |
| <input type="checkbox"/> Self      | <input type="checkbox"/> Health Insurance                |  |
| <input type="checkbox"/> Spouse    | <input type="checkbox"/> Nursing Home or Assisted Living |  |

**Specific information to be disclosed:**

- Report(s)**  
Date(s): \_\_\_\_\_ Procedure(s): \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
- Film(s)**  
Date(s): \_\_\_\_\_ Procedure(s): \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
- Duplicate files given to patient.

**This health information is needed for:**

- |   |                                       |                                      |
|---|---------------------------------------|--------------------------------------|
| <input type="checkbox"/> Continuing Medical Care    | <input type="checkbox"/> Personal Use | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Legal Reasons              | <input type="checkbox"/> Transfer     |                                      |
| <input type="checkbox"/> Social Security/Disability | <input type="checkbox"/> Insurance    |                                      |

I understand that the information in my health record may include information about my history, diagnoses and/or treatment. I authorize the disclosure of this specific information listed above. I understand that once the above information is disclosed, it may be re-disclosed by the recipient and federal privacy laws or regulations may not protect information. I recognize these films are the property of \_\_\_\_\_ and they are legally responsible for this permanent record. By signing this form, I agree to return original films in 30 days. Your signature allows us to release medical information to the parties designated above for one year.

\_\_\_\_\_  
Patient/Recipients Name (print)      Patient/Recipients Name (signature)

\_\_\_\_\_  
Phone Number

\_\_\_\_\_  
Witness