

THE IMAGING CENTER

Main: 970-282-2900 • Scheduling 970-282-2912 • Fax 970-282-9800

at Harmony: 2127 F. Harmony Road • Fort Collins, CO • 80528

PATIENT AUTHORIZATION FOR THE RELEASE OF PROTECTED HEALTH INFORMATION (PHI)

I, *(patient name)* _____, hereby authorize The Imaging Center, its agents, employees and associates to release the protected health information described below, to:

Name _____

Address _____ City _____ State _____ Zip _____

I authorize release of the following protected health information:

(Exam and exam date) _____ All Imaging Center Exams

This protected health information is to be used for the following purpose:

Referring Physician Self use Other: _____

This release may be revoked by a signed and properly dated written revocation, delivered to The Imaging Center provided that this release cannot be revoked as to 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 health information to the extent that it has already acted in reliance on this authorization.

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 a health care entity or any of its business associates.

I hereby authorize the use or disclosure of the health information described in this authorization. I understand that if anyone who receives my health information is not a health care provider or a health plan, my health information may not be protected by federal privacy laws if my health information is rediscovered by that recipient person or others.

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.

Proof of ID required.

This authorization will expire
1 year from:

_____/_____/_____
(Date signed)

Signature of Patient or Personal Representative

Relationship to Patient (if signed by Personal Representative)

Patient's Birth Date ____/____/____

Patient's Social Security Number _____ - _____ - _____