Medical Records Release

This authorization for disclosure of medical information is being requested to comply with the terms of the Confidentiality of Medial Information Act of 1981, Civil Code section 56 et seq and the Health Insurance Portability and Accountability Act, 1996 (HIPAA).

Patient name (print): ______________________________ **DOB:** ________________________

MR#:_____________ I hereby authorize Northern Arizona Radiology to release medical records.

Name of Physician, Facility or Person: ____

Address: ____

Phone #: ______________________________ Fax: __________________________________

Films to be release: ____

Reports only: ________ is this permanent transfer? (Mammograms only):__________

By signing below, I acknowledge receipt of the medical records and accept full responsibility for records released pursuant to this authorization and agree to hold harmless Northern Arizona Radiology for any action related to the release of these records, I understand that these original X-ray films are a permanent part of my patient record and I agree to return original X-ray films as soon as possible. If there are questions about reports, I will discuss them with my referring physician. I am aware that Northern Arizona Radiology may be unable to reproduce damaged or misplaced film(s). Records may not be released or transferred to another party without authorization by the patient, unless permitted by law.

____ ______________

Signature of patient or legal guardian Date

If signed by other than the patient, indicate relationship: _________________________________

____ ______________

Staff witness to signature Date

ID Checked: ________

For Office Use Only

Films to be available for pick-up by: Date:_____________ Time:_____________ a.m. / p.m.