KENT RADIOLOGY P.C.

Authorization To Release Protected Health Information (PHI)

This form must be completed for uses and disclosures of PHI not otherwise permitted under law and not included in our Notice of Privacy Practices.

TREATMENT WILL NOT BE WITHHELD FROM YOU IF YOU DO NOT SIGN THIS AUTHORIZATION**.

Patient Name: _____ I.D. No.: _____

Address: _____ Telephone _____

_____ Date of Birth: _____ _____ _____

Section A: Must be completed for all authorizations.

I hereby authorize the use and disclosure of my individually identifiable health information as described below. I understand that this authorization is voluntary. I understand that if the organization authorized to receive the information is not a health plan or health care provider the released information may no longer be protected by federal policy regulation.

Person/Organizations to receive the information specified below (Print clearly):

Name: _____ Address: _____

INFORMATION REQUESTED:

☐ Radiology Reports ☐ Billing Invoice ☐ X-Ray Films ☐ Other-

Date(s) Requested: _____ _____ _____

I authorize the release of health information contained in my medical records and understand that it may include sensitive information, for example:

PURPOSE OF DISCLOSURE:

☐ Attorney/Legal ☐ Auto Insurance ☐ **Employer (except: workers compensation) ☐ Disability Insurance ☐ Life Insurance

☐ Other (must specify) _____

It is further understood that the information released is for the specific purpose stated above and may not be provided in whole or part to any other agency, organization, or person unless otherwise identified in Kent Radiology's Notice of Patient Privacy; which I have received.

Section B: Personal Representative Authorization:

I authorize _____ (Relationship: _____) to act as my personal representative. I understand this allows him/her to receive personal health information as if being requested by myself.

Section C: Expiration Date (initial)**:**

_____. I understand that this authorization may be revoked by me at any time except to the extent that Kent Radiology, P.C. has taken action in reliance on the authorization. I may revoke by notifying Kent Radiology, P.C. in writing and sent to:

Privacy Officer, Kent Radiology, P.C., P.O. Box 186, Grand Rapids, MI 49501-0186.

_____. This authorization shall expire on: **Expiration date:** _____ **or** 60 days from the date signed.

**A faxed copy of this authorization shall have the same effect as the original.*

_____ _____

Signature of Patient (or Personal Representative if designation on file) Date

Office use:
Posted (initial)

**Exceptions may apply. Example: Employer sends you for a physical. We must disclose results to your employer.