RADIOLOGY ASSOCIATES, LLP
AUTHORIZATION FOR RELEASE OF PATIENT HEALTH INFORMATION

I AUTHORIZE RADIOLOGY ASSOCIATES, LLP TO RELEASE THE INFORMATION BELOW FROM MY HEALTH RECORD(S).

Patient Name (Please print): _____

Patient Address: _____

Date of Birth_____ Telephone # (required): _____

INFORMATION TO BE RELEASED:

☐ Itemized Billing Record for period _____ to _____ ☐ Complete Billing Record

☐ Medical Reports for period _____ to _____ ☐ Complete Medical Record

☐ Films/Images for period _____ to _____

☐ Other--Please Specify:

INFORMATION TO BE RELEASED TO:

Name: _____

Address: _____

City, State, Zip: _____

Telephone No: _____

METHOD OF DELIVERY:

Mail to address listed above: ☐ Office Pickup: (ID will be required): ☐

Note: Reports may be obtained through our patient portal. If you have not already been set up with a username and password for our patient portal, you may do so in person at any one of our office locations (ID will be required).

PURPOSE OF DISCLOSURE:

☐ Healthcare/Treatment ☐ Insurance ☐ Attorney ☐ Personal Use ☐ Other

I understand that

- A fee may be charged for preparing a copy of the requested records. This Authorization is voluntary. My treatment will not be impacted, no matter if I sign this Authorization or not.
- This Authorization is valid for one year from date signed, unless I revoke/withdraw this Authorization or unless an earlier date is specified here: _____.
- I may revoke/withdraw this Authorization, except to the extent that action has been taken prior to receipt of the revocation/withdrawal, by mailing or faxing my written request along with a copy of the original Authorization to our business office.
- Once my Health Information is 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.
- The medical information released may contain information related to HIV status, AIDS, sexually transmitted diseases, mental health, drug and alcohol abuse, etc**.**

Images will be provided in electronic format, unless otherwise specified. Any other protected health information will be provided to you in paper format. Important: I understand that the CD/disc is not encrypted or password protected and that it is my responsibility to take extra precautions to protect the data on the device and not to lose or misplace the device.

SIGNATURE:_____ DATE:_____
(Patient or Personal Representative)

_____

DESCRIPTION OF AUTHORITY TO ACT FOR PATIENT (if applicable)

Please mail or fax the completed form to:

Radiology Associates, LLP – 1812 S. Alameda St – Corpus Christi, TX 78411 – Fax: 361-561-3185