South Peninsula Hospital

4300 Bartlett Street Homer, Alaska 99603 **phone 907-235-0363 fax 907-235-0278**

IMAGING AUTHORIZATION TO USE & DISCLOSE HEALTH INFORMATION

Notice: This request is not valid unless all requested information is provided.

Release From: Name: South Peninsula Hospital Imaging Department Phone:907-235-0363 Fax:907-235-0278

Release To: Name: _____ Phone: _____

Address: _____

Patient Identification:

Patient Name: _____ Date of Birth: _____

MR # : _____ Telephone(s) #: _____

Please check type of information to be released:

❒ FILM ❒ REPORT ❒ CD	**DATE(S) OF SERVICE**	**ACCOUNT NUMBER(S)**
❒ CT		
❒ MRI		
❒ XRAY		
❒ US		
❒ DEXA		
❒ MAMMOGRAM		

Received by: ❒ Mail ❒ Pick-up ❒ Fax: _____ ❒ Date completed: _____
❒ # of pages _____ ❒ Initials of individual preparing release of records_____

Purpose of the Request:
❒ Personal (at the request of pt.) ❒ Continued Care ❒ Legal ❒ Insurance ❒ Government
❒ Other (specify): _____

Terms
I understand that authorizing the disclosure of the above information is voluntary and I need not sign this form to ensure treatment. I understand that the information in my health record may include records relating to sexually transmitted diseases, drug and/or alcohol abuse treatment, psychiatric care or other sensitive information.

Expiration & Right to Revoke Authorization
Except to the extent that action has already been taken in reliance on this authorization, at any time I may revoke this authorization by submitting a notice in writing to the Health Information Management Department. Unless revoked earlier, this authorization will expire six months from the date on which it was signed, or upon the following date or event:

_____

Re-disclosure
I understand that once the above information is disclosed, it may be subject to re-disclosure by the recipient and no longer protected by federal privacy laws or regulations.

Signature: _____ **Date**: _____

If signed by legal representative, relationship to patient:

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The Radiology Department at SPH is pleased to provide you with one free copy of your films or CD of your exam if you are taking the copy to an out-of-town physician office or being transferred to another facility. However, due to the high cost of duplicating films, **additional copies will be provided for a fee of $ 8.00 per film, CDs $15.00.** To help avoid the expense of additional copies, we suggest that you keep your free copy in your personal files for future use.

Tracking information _____