



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:

<input type="checkbox"/> REPORT <input type="checkbox"/> CD	DATE(S) OF SERVICE	ACCOUNT NUMBER(S)
<input type="checkbox"/> CT		
<input type="checkbox"/> MRI		
<input type="checkbox"/> XRAY		
<input type="checkbox"/> US		
<input type="checkbox"/> DEXA		
<input type="checkbox"/> 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: \_\_\_\_\_

### IMAGING AUTHORIZATION TO USE & DISCLOSE HEALTH INFORMATION

The Imaging Department at SPH is pleased to provide you with one free copy of a 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 CDs, **additional copies will be provided for a fee of \$15.00 per CD.** 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 \_\_\_\_\_