

Imaging Authorization: Release of Health Information

South Peninsula Hospital | 4300 Bartlett St. | Homer, AK 9960

Patient Identification:

Name:	Date of Birth:
Address:	
Phone(s):	MR#:

Non-Diagnostic Image Capture/Picture Only

Imaging recorded by patient for personal use Signature: _____ Date: _____

Imaging Authorization Release From:

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

Release of Imaging To:

Name:	Phone:
Email:	Fax:
Address:	

Information to be Released:

Please check type of information to be released and include all Modalities you requested imagery from

Modality:

- CT MRI X-Ray Dexa Mammography Ultrasound

Format:

- Printed Report
 CD/DVD
 Email to user (*Powershare*)
 Transmitted to facility (*Powershare*)

Received by:

- USPS
 Pick-up
 Fax
 Email
 Powershare

Purpose of Request:

- Personal (patient request)
 Treatment
 Insurance
 Government
 Legal
 Other: _____

Date(s) of Imaging Service/Study/Body Part	Account Number(s)



Additional authorizations are required for the release of any imaging information pertaining to Substance Use Disorder (SUD) treatment or sexually transmitted infections. Refer to next page for additional details.

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Patient Label

Imaging Authorization: Use & Disclosure of Health Information

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 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 one year** from the date on which it was signed, or on the following date or event: _____, whichever comes first.

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.

CONSENT OF A MINOR

With certain age restrictions, a minor patient's signature is required in order to release information concerning care for:

- 1) Pregnancy termination and sexually transmitted diseases
- 2) Drug or alcohol treatment
- 3) Mental health conditions

DRUG AND ALCOHOL TREATMENT INFORMATION

Federal regulation (42 CFR part 2) prohibits any further disclosure of this information except with specific written consent of the person to whom the information pertains or the parent/legal guardian of a minor child to whom it pertains, unless otherwise permitted by federal law. A general authorization for the release of information is NOT sufficient for this purpose. The Federal rules restrict any use of information to criminally investigate or prosecute any alcohol or drug treatment patient. Federal regulations state that any person who violates any provision of the law shall be fined in accordance with 42 USC 290dd-3 and 42 USC 290ee-3.

SEXUALLY TRANSMITTED INFECTIONS INFORMATION (Includes HIV / AIDS)

State law prohibits any further disclosure of this information without specific written consent of the person to whom the information pertains, or the parent/legal guardian of a minor child to whom it pertains, unless permitted by state law. A general authorization for the release of information is NOT sufficient for this purpose. Any violation of the law is a gross misdemeanor, and the law creates civil remedies for any violations including fines as defined under Alaska Statute 18.15.400(f).



Use of "Special Authorization: Release of Select Health Information [FORM HW.ROI.004] is mandatory for the release of any imaging information pertaining to substance use disorder treatment and care, or sexually transmitted infections.

Patient/Representative Signature: _____ Date: _____ Time: _____

Name Printed: _____

If signed by legal representative, relationship to patient: _____

For Office Use Only

Date Received: _____ Date Completed: _____ # Of Pages Released: _____ Completed By: _____

Information Released: _____

Date Sent: _____ Method: _____ Fax # Sent to: _____ ID Checked By: _____

