PREFERRED IMAGING
EXCELLENCE IN DIAGNOSTIC IMAGING

Authorization for Use or Disclosure of Protected Health Information
Request for Patient Records

By signing this form I authorize *Preferred Imaging* to receive Confidential Health Information about me

Patient Information:

Patient Name: _____ Date of Birth: _____
(first) (m. initial) (last)

Patient Address: _____ Phone: _____
(street address) (city) (state) (zip code)

Patient information to be released to Preferred Imaging: I hereby authorize the release of the following information to Preferred Imaging

Entire Record	Clinic Visit Notes	Surgical Notes	Test Results
Diagnostic Images	Diagnostic Reports	Mammogram	Other_____

For the following date/treatment: _____

From the following facility/facilities

Facility Name: _____ Facility Name: _____

Facility Address: _____ Facility Address: _____

_____ _____

_____ _____

Acknowledgement:

- I am specifically authorizing the release of the above information to Preferred Imaging
- I understand that I may change my mind and revoke this Authorization in writing at any time by notifying Preferred Imaging
- I understand that this form is voluntary, I may refuse to fill out/sign this form

By signing below, I represent and warrant that I have authority to sign this document and authorize the use of disclosure of protected health information and that there are no claims or orders pending or in effect that would prohibit, limit, or otherwise restrict my ability to authorize the use or disclosure of this protected health information.

Patient Signature: _____ Date: _____

If you are not the patient but are signing on behalf of the patient, please check the one that applies

___ Parent with Parental Rights ___ Court Appointed Guardian ___ Power of Attorney with Right to See Medical Records ___ Other: _____

Representative's Signature: _____ Date: _____
You must attach proof of your authority to act on behalf of the patient as checked above (other than parent)

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