AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

Patient Name:_____ **Patient Date of Birth:**_____

Patient Address:_____

City, State, Zip:_____ **Phone:**_____

I hearby authorize _____ **to disclose my protected health information, as described below, to:**
Facility or Doctor to make record disclosure

BMX IMAGING CENTER
1069 Delaware Ave Ste 104B
Marion, OH 43302

My authorization extends only to the following data elements/documents:

- ☐ **Diagnostic Imaging Reports**
- ☐ **Statements of charges or payments**
- ☐ **For all records from_____ to _____**
- ☐ **Consultation Reports**
- ☐ **Photographs, videotapes, digital or other images or films (MRI Scans, CT Scans, etc.)**
- ☐ **History and Physical**
- ☐ **Problem List**
- ☐ **Laboratory Results**
- ☐ **Medication List**
- ☐ **ALL OF THE ABOVE**
- ☐ **Other (Please Specify)_____**

I understand that the information I authorize a person or entity to receive may be re-disclosed and no longer protected by federal privacy regulations.

I understand that this authorization is voluntary and that I may refuse to sign this authorization. My refusal to sign will not affect my eligibility for benefits, payment for, or coverage of services, or ability to obtain treatment.

I understand that I have the right to cancel this authorization, in writing, at any time by presenting my written cancellation to: BMX Imaging Center, 1069 Delaware Ave Ste 104B, Marion, Ohio 43302. I understand that a cancellation will not apply to information that has already been released under this authorization. I understand that the cancellation will not apply to my insurance company when the law gives my insurer the right to contest a claim under my policy.

I UNDERSTAND THAT THIS AUTHORIZATION WILL (initial <u>ONLY ONE</u> of the following):

_____ Expire one year from the date signed by the patient or patient's personal representative;

<u>OR</u>

_____ Be effective for the lifetime of the patient unless revoked by the patient or patient's personal representative.

I acknowledge that I have read this Authorization, and that I understand my rights described herein.

_____ _____
Signature of Patient or Patient's Personal Representative **Date**

_____ _____
Printed Name of Patient or Patient's Personal Representative **Relationship to Patient**