EXECUTIVE IMAGING, LLC

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

EXECUTIVE IMAGING CENTER
1069 Delaware Ave Ste 104
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: Executive Imaging Center, 1069 Delaware Ave Ste 104, 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 ONLY ONE of the following):

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