Authorization For Release of Protected Health Information
The Imaging Center

PATIENT NAME: _____ **DOB:** _____
Last **First** **M.I.** **AX#** _____
MR # _____

I authorize: Hunt Regional Medical Center **To release to:** _____
Address: 4215 Joe Ramsey Blvd. Address: _____
Greenville, TX 75401 _____
Phone #: (903) 408-1230 Phone #: _____

This information is needed for the purpose of: ☐ at the request of the individual
☐ Medical Care ☐ Insurance ☐ Litigation ☐ Other _____

Date information is needed: _____. Information is to be sent via:
☐ Patient to pick up records ☐ Send by Mail ☐ Fax to _____

TREATMENT DATES TO BE INCLUDED: _____ **to** _____

Patient type: _____

Please check all applicable information requested:

☐ Radiology Film of _____
☐ MRI of _____
☐ Mammography Film _____
☐ CT of _____
☐ Ultrasound Film of _____
☐ Nuclear Medicine Film of _____

*Please document accession numbers for studies being released.

I request and authorize the above named health care provider to release the information specified to the organization, agency, or individual named on this request. This authorization is subject to revocation at any time except to the extent that action has been taken and expires **180** days from the date signed. Treatment, payment, enrollment or eligibility for benefits may not be conditioned on signing this authorization. The facility to whom this authorization is directed, its employees and authorized representatives are hereby released from legal responsibility or liability for the provision of information as authorized above. I understand that the information that is being released is subject to re-disclosure by the recipient and is no longer protected.

_____ _____
Signature of Patient ***Date***

If the patient is unable to sign or is a minor, complete the following:
☐ **Minor of _____ age**
☐ **Unable to sign because:**
_____

_____ _____
Signature of Authorized Party ***Date***

_____ _____
Signature of Witness ***Date***

☐ **Durable Power of Attorney**
☐ **Legal Guardian**
☐ **Other** _____

Form HIPPA-007(N-4/14/03)
Revised 7/06/12