

Authorization For Release of Protected Health Information
Diagnostic Imaging Services

Patient Name: _____
Last First M.I.

DOB: _____
SSN# _____
MR # _____

I authorize: Hunt Regional Medical Center
Address: 4215 Joe Ramsey Blvd.
Greenville, Texas 75401
Phone #: 903-408-1230

To release to: _____
Address: _____
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:

- Radiographic Images OF : _____
- MRI(s) _OF : _____
- Mammography Images : _____
- CT'(s) OF : _____
- Ultrasound (s) OF: _____
- Nuclear Medicine Images, OF : _____

*All Images are reproduced on CD, unless specifically requested as FILM. All FILM reproductions require a \$17.50/film payment, payable in advance of delivery.

*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 which 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**

Signature of Authorized Party **Date**

- Durable Power of Attorney**
- Legal Guardian**
- Other:** _____

If the patient is unable to sign or is a minor, complete the following:

- Minor of _____ age**
- Unable to sign because:** _____

Signature of Witness **Date**