REGIONAL RADIOLOGY
REGIONAL IMAGING & THERAPEUTIC RADIOLOGY SERVICES, P.C.

360 Bard Avenue • Staten Island, New York 10310 • (718) 876-2000 • Fax (718) 876-2006

AUTHORIZATION FORM FOR PATIENT RECORDS RELEASE

PLEASE FAX COMPLETED FORM TO 718-876-2012

Section A: Must be completed for all authorizations

I hereby authorize the use and disclosure of my individually identifiable health information as described below. I understand that this authorization is voluntary. Any health information disclosed pursuant to this authorization may be subject to redisclosure by the recipients and may no longer be protected by the Federal privacy regulations.

Patient name:_____
_____
_____

ID Number (if applicable): _____
Date of Birth_____
SS#_(last four digits)_____

Persons/organizations authorized to use or disclose my information: _____
_Regional Radiology_____
_____

Persons/organizations who may receive my information: _____
_____
_____

Specific description of the information to be used or disclosed (including date(s)): _____
_____
_____

Description of each purpose of the use or disclosure of my health information: (Note: If the release of information is requested by the patient, please insert "at the request of the patient" here if the patient does not provide a statement of purpose.)

_____
_____
_____
_____

For marketing authorizations only: If this authorization will allow the use of patient information for marketing purposes, please indicate whether the marketing involves any direct or indirect remuneration from a third party to the Practice:

_____

_____

Magnetic Resonance • Computed Tomography • Mammography • Radiography/Fluoroscopy • Diagnostic Ultrasound • Nuclear Medicine • Radiation Therapy

Section B: The patient or the patient's representative must read and initial the following statements

1. I understand that this authorization will expire on _____ Initials_____
   [Insert Expiration Date or Event]

2. I understand that I may refuse to sign this form and that my health care and the payment for my health care will not be affected if I do not sign this form. Initials_____

3. I understand that I will get a copy of this form after I sign it. Initials_____

4. I understand that I may revoke this authorization at any time by notifying the Practice in writing, but if I do, the revocation will not have any effect on actions the Practice has already taken in reliance on this authorization. Initials_____

_____ _____

Signature of patient or patient's representative **Date**

(Note: *This form MUST be completed before signing.*)

If this authorization is signed by a patient's representative, please complete the following:

_____

Printed name of patient's representative:

_____

Relationship to the patient:

Describe the representative's authority to act for the patient:

_____

_____

_____

** YOU MAY REFUSE TO SIGN THIS AUTHORIZATION **