Authorization for Use or Disclosure of Protected Health Information

When you complete and sign this form, health information about you will be released as you describe in the form. Please read each section carefully and complete the required sections before signing. We encourage you to request a copy of you records and review them before authorizing the release of the records to someone other than you. Please clearly and legibly print all information when completing this form and sign on the last page.

Patient Name: _____ Date of Birth: _____

MRN # (If Known): _____ Phone Number: _____

Please describe the specific health information you would like released by completing the appropriate information below:

Exam: _____ Date of Service: _____

Exam: _____ Date of Service: _____

Exam: _____ Date of Service: _____

You would like this information released via the following method: (Please select one of the following)

☐ Mail ☐CD/DVD ☐Fax ☐Pick up in person ☐Electronic File (Patient requests only)

If **Mail**, provide Address:

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

If **Fax**, provide Fax number: _____

If **email** (not encrypted), provide email address: _____

Your Privacy Rights:

- You may refuse to sign this authorization. Our refusal will not affect your ability to obtain treatment or insurance payment or eligibility for benefits.
- You may revoke this authorization at any time, but you must do so in writing and submit it to the following address: **Elite Diagnostic Imaging, 9758 East 21st Street North Suite 300 Wichita, KS 67206**
- You have a right to receive a copy of this authorization.

Cautions before signing:

- Your health information that will be released as a result of you signing this authorization could be re-disclosed by the recipient. If this occurs, your re-disclosed health information may no longer be protected by state or federal privacy law.
- We encourage you to request a copy of your records and review them before authorizing the release of the records to someone other than you.
- The release of this information may involve certain risks, such as re-disclosure by the recipient, loss or compromise of insurance benefits, or employment status.
- If you have questions about this authorization form or the release of your health information, please as a staff member for further explanation.

Please sign and date this form to authorize Elite Diagnostic Imaging to release your information as stated on this form.

Name of patient (please print): _____

Name of legal representative, if applicable (please print): _____

Address of patient or legal representative signing this form:

_____

Phone number of patient or legal representative signing this form: _____

Signature: _____ Date: _____