Precise Imaging

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Authorization to Release Medical Records

(Required by the Health Insurance Portability and Accountability Act or HIPAA, 45 C.F.R. Parts 160 and 164)**

1. Authorization

I authorize Precise Imaging to use and disclose the protected health information (PHI) described below to

_____ (parties seeking the information).

2. Effective Period

This authorization for release of information covers the period of healthcare from:

a. ☐ _____ to _____

OR

b. ☐ All past, present and future periods.

3. Records to Release

I authorize the following records to be released:

☐ Medical Report ☐ Radiological Imaging ☐ Other_____

This medical information may be used by the person I authorize to receive this information for medical treatment or consultation, billing or claims payment, or other purposes as I may direct.

I understand that I have the right to revoke this authorization, in writing, at any time. I understand that a revocation is not effective to the extent that any person or entity has already acted in reliance on my authorization or if my authorization was obtained.

I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

Clear Form

_____ _____

Signature of patient or personal representative Date

_____ _____

Printed name of patient or personal representative Relationship to Patient