SPRING HILL IMAGING CENTER

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AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

Patient Name ______________________________ Med Rec#______________________

Date Of Birth ______________________________

Address ______________________________ SS#______________________

I authorize Spring Hill Imaging Center to release copies or other facsimiles of information relating to my care to:

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Purpose: Further Care ___ Legal ___ Insurance ___ Other ___

This information may include treatment or rehabilitation for drug and/or alcohol abuse, psychiatric treatment, or HIV test results, an AIDS diagnosis or AIDS-related condition, if they did occur. I specify that this release is to include:

___ Discharge Summary
___ Operative Reports
___ History & Physical
___ Laboratory Reports
___ Pathology Reports
___ Consultation Reports
___ EKG Reports
___ Emergency Room Reports
___ X-ray Reports
___ Pharmacy Pt. Prescription Profile
___ Billing Records
___ Other (Please Specify) ______________________

Treatment Dates: ______________________________

The facility is authorized to furnish this information even though the confidentiality of the information may be protected by Federal and State laws and regulations. The facility is hereby released and discharged of any liability, and I will hold the facility harmless for complying with this authorization. I understand that once the information is disclosed pursuant to this authorization, it may be re-disclosed by the recipient and the information may not be protected by Federal privacy regulations, I understand that I do not have to sign this authorization in order to receive treatment, payment, or eligibility for benefits.

This authorization will remain in effect for 1 year. I understand that this authorization can be withdrawn at any time. Revoking this authorization stops further disclosures but cannot undo any disclosures that may have already occurred as requested in the original authorization.

Signature ______________________________________ Date ______________

If the above signature is not that of the patient, please explain why. Documentary evidence of guardianship may be required to accompany this form.

Medical Information Release To: ______________________________ Date ______________