IMAGING AUTHORIZATION TO RELEASE HEALTH INFORMATION

INSTRUCTIONS FOR COMPLETING FORM: Please write legibly and complete all sections as indicated. Return the completed and signed form to:
FirstHealth Moore Regional Hospital PO Box 3000, Pinehurst, NC 28374 ATTN: Imaging Fileroom or Fax to 910-715-1408

Printed Patient Name (Last, First, Middle Initial)	Birth Date (MM/DD/YYYY)	Last 4 of Social Security Number	MR# -Internal Use

Mailing Address (Include Street/PO Box, City and Zip Code)	Telephone# (Including Area Code) ( )

Date/s of Treatment Covered Under Request	Date Copies Needed By	Mail ☐ Pick-up ☐ (Positive ID Required)

I hereby authorize: ☒ _____

☐ _____

to release copies of records on the above patient to ☐ myself ☒ Other ATTN: Imaging Fileroom

ADDRESS **FirstHealth of the Carolinas-Moore Regional Hospital, 155 Memorial Drive PO Box 3000 Pinehurst, NC 28374**
(Indicate complete mailing address if different from patient address).

PHONE NUMBER _____ **FAX NUMBER** _____

☐ **Telephone Consent by Patient to release CD with report to person named above taken by:** _____

☐ **Called medical records per** _____ **verified a valid POA is on file to the person named above.**

INFORMATION TO BE RELEASED INCLUDES (*Check applicable box/s and indicate other information in the space below*.

☐ Angiograpy ☐ CT ☐ MRI ☐ Nuclear Medicine
☐ Ultrasound ☐ X-Ray ☐ Report included on CD
☐ Other _____

PURPOSE OF RELEASE _____

I understand that this authorization is voluntary and that I may refuse to sign it. I need not sign this form to ensure healthcare treatment or payment for such treatment.

This authorization is void 180 days after the date signed or anytime I, as the patient, guardian, or legally authorized representative make a **specific written request to the entity noted above to revoke** the authorization. Such revocation shall be effective *except* to the extent that the facility has already used or disclosed information in reliance on the authorization.

!!! I understand that once information is used or disclosed based on this authorization it may be re-disclosed by the recipient and at such time may no longer be protected by federal privacy laws or regulations. ☐ Patient was informed of statement

_____ _____
Signature of Patient/*Individual With Legal Authority to Sign** **Date/Time**

_____ _____
Signature of Witness **Date/Time**

******THE FOLLOWING SECTION MUST BE COMPLETED WHENEVER PATIENT IS UNABLE TO PERSONALLY SIGN FOR RELEASE** OF PROTECTED HEALTH INFORMATION.*

Patient is unable to authorize release of records/information as a result of the following **(check one):**

☐ Patient is a minor, ☐ Patient is mentally incompetent, ☐ Patient has a physical disability that prohibits signing, or

☐ Deceased/Other (clearly state reason if other)_____

NOTE: If the patient is deceased, only the executor and/or administrator of the estate or next-of-kin may authorize release of copies of medical records. Documentation reflecting such individuals' legal authority to sign for release of records must be provided.

FirstHealth
MOORE REGIONAL HOSPITAL

Authorization to Release Health Information
Imaging (Requesting from another Facility)
Original: Patient Chart

1ROI001

Place Patient Label
Inside This Box