

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 <input type="checkbox"/> Pick-up <input type="checkbox"/> (Positive ID Required)	

I hereby authorize: **FirstHealth – Moore Regional Hospital**

to release copies of records on the above patient to myself Other ATTN: _____

ADDRESS _____
(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.)*

- | | | | |
|--------------------------------------|--------------------------------|--|---|
| <input type="checkbox"/> Angiography | <input type="checkbox"/> CT | <input type="checkbox"/> MRI | <input type="checkbox"/> Nuclear Medicine |
| <input type="checkbox"/> Ultrasound | <input type="checkbox"/> X-Ray | <input type="checkbox"/> Report included on CD | |
| <input type="checkbox"/> 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.



**Authorization to Release Health Information
 Imaging (Sending to another Facility)
 Original: Patient Chart
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