AUTHORIZATION FOR USE & DISCLOSURE OF PROTECTED HEALTH INFORMATION

Patient Identification:

Printed Name: _____ Date of Birth: _____

Social Security Number: _____

Information to be Release – Covering the Periods of Health Care:

From (date): _____ to (date): _____

Type of Information to be Released:

X-Ray Report(s) Ultrasound Report(s) CT Scan Report(s) MRI Scan Report(s)

Part of Body: _____

Where to Send/Release Requested Information:

Tri-Lakes Diagnostic Imaging
P.O. Box 1075
Branson West, MO 65737
Phone: (417) 739-5640
Fax: (417) 739-1323

From/To: _____

Phone: _____

Fax: _____

If you have received a complimentary copy of your records, please refer to our website at www.tldcares.com for additional copies.

Time Limit & Right to Revoke Authorization

Except to the extent that action has already been taken in reliance on this authorization, at any time I can revoke this authorization by submitting notice in writing to the health care provider's privacy coordinator or officer. Unless revoked, this authorization will expire on the following date or event, **one year from the date of this authorization,** unless otherwise specified. I have the right to inspect the health information to be released unless prohibited by law. I may refuse to sign this authorization, and my treatment or payment for services will not be denied if I do not sign this form unless it is for research related treatments or provided solely to give information to a third party as specified under Purpose of Request. I can inspect or copy the protected health information to be used or disclosed.

Signature: _____ **Date:** _____