INVISION SALLY JOBE
Imaging by RIA and HealthONE

Centralized Medical Records
8200 E. Belleview Ave. Suite 200E, Greenwood Village, CO 80111
Phone (720) 493-3242 / Fax (720) 874-4433

AUTHORIZATION TO USE AND/OR DISCLOSE PROTECTED HEALTH INFORMATION

Patient Name: _____ DOB: _____ MRN: _____
(PRINT)

Patient Name on Previous Records (maiden name or nickname): _____
(PRINT)

☐ **Release** Reports (mail, fax, or email) ☐ **Release** Images (mail or pick up) ☐ **Release** Reports and Images

To ☐ Patient ☐ Physician ☐ Other: _____

Send by:
☐ Mail
☐ Fax
☐ Email

Address: _____
City: _____ State: _____ Zip Code: _____
Phone: _____ Fax: _____
Email address: _____

☐ **Request** Reports and/or Images:

From ☐ Facility ☐ Physician: _____
Address: _____
City: _____ State: _____ Zip Code: _____
Phone: _____ Fax: _____

☐ All Records

☐ Specific Exam: ☐ X-ray ☐ Mammogram ☐ Ultrasound ☐ CT ☐ MRI ☐ Other: _____

Specific Exam Date: _____ Specific Date Range: _____

Purpose: ☐ Comparison ☐ Continuation of Care ☐ Workers' Compensation ☐ Attorney ☐ Insurance ☐ Other

Reports and/or images needed by: _____

I understand that:

- It is important for a physician to explain the information contained in medical records and to have follow-up care as needed.
- I am not required to authorize the disclosure of my medical record to a third party and that my authorization to disclose is strictly voluntary.
- My treatment, payment, enrollment or eligibility for benefits may not be conditioned on signing this authorization.
- I may revoke this authorization at any time in writing to the address on the top of this form, but if I do, it will not have any effect on any actions taken prior to receiving the revocation. Further details may be found in the Notice of Privacy Practices.
- This authorization will expire, without my expressed revocation, either one year from the date of signing or the date the minor child becomes an adult according to state law, whichever occurs first.
- If the requestor or receiver of the medical record is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations and may be disclosed by the receiver without my knowledge or authorization.
- I may see and obtain a copy of the information described on this form, for a reasonable fee, if I request it.
- I can receive a copy of this form after I sign it.
- If I have any questions about my privacy rights, I may contact the RIA/Invision Privacy Officer at (720) 493-3731.

I have read the above and authorize the disclosure of the protected health information as stated.

Signature of Patient: _____ Date: _____

Legal Representative: _____ Date: _____

Witness: _____ Date: _____