



**AUTHORIZATION TO USE AND/OR DISCLOSE PROTECTED HEALTH INFORMATION
RELEASE REPORTS & IMAGES**

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

Release **Reports**: mail email: _____ fax
 pick up from Invision Sally Jobe (Special instructions: _____)
(OFFICE USE)

Release **Images**: mail
 pick up from Invision Sally Jobe (Special instructions: _____)
(OFFICE USE)

To Patient Physician Other: _____

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 this date: _____

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: _____