INVISION SALLY JOBE
Imaging by RIA and HealthONE

# Centralized Medical Records

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## 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 _____

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 requester 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 420.493.3731.

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 _____