INVISION SALLY JOBE
Imaging by RIA and HealthONE

Centralized Medical Records
Phone 720.493.3242 / Fax 720.874.4433
Email: medical.records@riaco.com

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

All information must be completed or we will be unable to fulfill your request.

Patient Name: ______________________________ (PRINT) DOB: ______________ MRN: ______________ (OFFICE USE)

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

RELEASE: ☐ Reports (mail, fax, or email) ☐ Images (mail or pick up) ☐ Reports and Images

To: ☐ Patient ☐ Physician/Facility Name ______________ ☐ Other ______________

Send by: ☐ Mail ☐ Fax ☐ Email

Address: ______________________________

City: ______________________________ State: __________ Zip Code: ______________

Phone: ______________________________ Fax: ______________________________

Email: ______________________________

☐ All Records

☐ Specific Exam: ☐ X-Ray ☐ Ultrasound ☐ CT ☐ MRI ☐ All breast imaging ☐ Genetic Counseling
☐ 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: ______________________________

PRIORS: Request to obtain prior reports and images only: **FAX:** 720.874.4439 **EMAIL:** prior.records@riaco.com

REQUEST: ☐ Prior Reports and/or Images:

From: ☐ Facility ☐ Physician: ______________________________

Address: ______________________________

City: ______________________________ State: __________ Zip Code: ______________

Phone: ______________________________ Fax: ______________________________

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 Compliance Hotline Number at 720.493.3788.

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: ______________

© 2022 Invision Sally Jobe 9-14-22