ARIZONA MRI
a Pain Doctor Company

AUTHORIZATION FOR AZ MRI TO DISCLOSE HEALTH INFORMATION

Patient Name: _____Patient Date of Birth: _____ Phone:_____

Health information to be disclosed: (check appropriate box)

MRI Images_____ MRI Report_____

Date of Imaging_____ Area of Imaging_____
Date of Imaging_____ Area of Imaging_____
Date of Imaging_____ Area of Imaging_____
Date of Imaging_____ Area of Imaging_____

I authorize Arizona MRI to disclose the following health information of mine to the following Recipient

Recipient of health information:
If the recipient is intended to be the undersigned patient (yourself), please specify how you would like to receive records:☐ Fax (please specify number below)☐: I will pick them up from the office☐: Mail

Name or Doctor: _____
Phone: _____
Fax: _____
Address: _____

I understand I may revoke this Authorization at any time by sending written notice of my revocation to APS's health information management department. I understand that my revocation will not be effective to the extent the healthcare provider has taken action in reliance on this Authorization.

Unless revoked sooner, this Authorization will expire on the following date, event, or condition: _____ _____. If no date, event, or condition is written, this Authorization will expire 1 year from the date signed. A photocopy of this Authorization will be considered effective and valid as the original.

I understand that AZ MRI may not condition treatment, payment, enrollment, or eligibility for benefits on whether I sign this authorization. I understand that the Recipient may redisclose the records and that the records may no longer be protected by Federal privacy regulations.

Please Note: Fees May Be Charged For Copying Medical Records

I have read this Authorization and I acknowledge that I am familiar with and fully understand its terms and conditions.

X_____ _____
Signature of Patient / Parent / Guardian or Authorized Representative Date
(Guardian or Authorized Representative must attach documentation of such status.)

_____ _____
Printed name of Authorized Representative and Telephone Number Relationship / Capacity to Patient