Patient/Representative Access to Protected Health Information

Pursuant to the Health Insurance Portability and Accountability Act (HIPAA), I hereby authorize Oregon Imaging Centers to disclose my radiology/medical record(s). Please provide the following information.

_____ _____

Patient's Name - **Last, First, Middle** Phone number

Date of Birth: _____/_____/_____

Please mark **one** of the following:

( ) Radiology exam date of service: _____ to _____

( ) All radiology records/reports

This information is to be disclosed to:

_____

Name of Physician, Patient, and/or Patient Representative

_____

Address City/State Zip Code

According to the Privacy Notice, I understand that this authorization may be revoked in writing at any time, except to the extent that action has been taken in reliance on this authorization.

I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law.

Unless otherwise revoked, this authorization will expire in two (2) years. The facility, its employees, officers, and physicians are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein.

_____ ____/____/_____

Signature of Patient/Legal Representative Date