RADIOLOGY

Patient/Representative Access to Protected Health Information

3501 Health Center Blvd, Bonita Springs Fl 34135
Tel 239-949-6105 Fax 239-949-6125

Pursuant to the Health Insurance Portability and Accountability Act (HIPAA), I hereby authorize the Radiology Department of Bonita Community Health Center to disclose the following information from the Radiology records of:

Date: ____________

______________________________________ __________________________
Patient's Full Name **Phone number**

Date of Birth_____/_____/_____ Patient Medical Record #__________________

Radiology exam date(s) of service: ____________ to __________

Radiology information to be disclosed: (**All images will be provided on CD-ROM)**

MRI _____ **Ultrasound** _____ **CT Scan** ______ **Mammogram** ______ **X-ray** ______

This information is to be disclosed to ____
Physician's Name -or- Patient Copy

____
Address City/State Zip Code

__________________________ **Patient Picked up / Send to Physician**
Phone Number (circle one)

According to the Privacy Notice, I understand that this authorization may be revoked in writing at anytime, 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 90 days. 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

_________________________________ ____/____/_____
Signature of Witness Date

ALL CD REQUEST WILL BE CONFIRMED WITH THE PHYSICIAN'S OFFICE. THERE WILL BE A CHARGE OF $5.00 ($10 TO MAIL THE CD) FOR ANY CD'S NOT REQUESTED BY A PHYSICIAN'S OFFICE.

For internal use only:

Patient Paid: _____ **CD Made:** _______________ **Patient Picked Up:** _____ **Scanned:** _____
Date/Initials