VALLEY
MRI & RADIOLOGY, INC.

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

Patient Name:		
(First)	*(Middle)*	*(Last)*
Address:		
(Street Address)		
(City)	*(State)*	*(Zip Code)*
MR#:	**Date of Birth:**	

I AUTHORIZE VALLEY MRI AND RADIOLOGY INC TO RELEASE MY MEDICAL RECORDS TO:

Person/Organization:	**Relationship:**
Address:	
City/State/Zip:	
Phone:	**Fax:**

Date of Service(s): _____

Type of Health Information to Release:

☐ Radiologic Report ☐ Billing Record ☐ Films ☐ CD

Delivery Instructions:

☐ Mail to Person/Organization ☐ Pick up from Medical Records

☐ Additional Physicians to CC copies of reports: ☐ Deliver to local area

☐ Facility Pick-up ☐ Fax Report ☐ Patient Handcarry

_____

_____ Fax #: _____

_____

I understand that:

- This authorization is voluntary. My treatment will not be impacted, no matter if I sign this authorization or not.
- If I do not sign this authorization, Valley MRI And Radiology Inc. will not disclose my health information as requested.
- I will receive a copy of this authorization upon signature.
- This authorization is valid for one year from date signed, unless I revoke this authorization or unless an earlier date is specified here: _____. I may revoke this authorization by mailing or faxing my written request along with a copy of the original authorization to Valley MRI And Radiology Inc.
- Once my health information is disclosed as requested, it may no longer be protected by federal and state privacy laws, and could be re-disclosed by the person(s) receiving it.
- The medical information released may contain information related to HIV status, AIDS, sexually transmitted diseases, mental health, and drug or alcohol abuse.

Signature: _____ **(Patient or Legal Representative)**

Date: **Legal Representative Relationship:** _____

Valley MRI Representative: _____

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