ANNA JAQUES HOSPITAL

Authorization for Release of Protected or Privileged Health Information

Photocopy of Patient License here

Patient Name (Please Print)	
Patient Medical Record #	Date of Birth / /
Patient Address (Street {apt #}, City, State ZIP)	
Patient Telephone Contact #'s	

I, ____,
Patient Name

do hereby authorize Diagnostic Imaging Studies to release my protected health information including copies of my medical record/x-ray scans or reports of care received at your facility to the following person(s) at the locations/facilities listed below, for the purposes described:

Person(s)/Facility/Address (*include Name and Address*)

1. ______________________

2. ______________________

Purpose (*check appropriate box*)

- ❑ Medical Care
- ❑ Personal
- ❑ Insurance
- ❑ School
- ❑ Legal Matter
- ❑ Other (*please specify*) ______________________

Information to be Released (*please check all that apply and specify dates*)

❑ CT Scan *Date:*	❑ MRI *Date:*	❑ Reports *Date:*
❑ Mammogram *Date:*	❑ Ultrasound *Date:*	❑ Diagnostic Imaging *Date:*

I understand that: I may withdraw my authorization at any time by submitting a written request to the Director of Health Information Management at Anna Jaques Hospital (AJH) or the Office Manager in my physician's office. Authorization may be withdrawn except for the following:

- To the extent that action has been taken in reliance on this authorization
- If the authorization is obtained as a condition of obtaining insurance coverage, other laws provide the insurer with the right to contest a claim under the policy.

I may refuse to sign this authorization. If I refuse to sign this authorization, my treatment, payment, health plan enrollment or eligibility for benefits will not be affected.

Information released on this authorization, if re-disclosed by the recipient, is no longer protected by AJH.

I understand that this authorization will automatically expire (*please check one*):

❑ In 6 months ❑ Upon a specific event (*specify event*) ______________________

I have carefully read and understand the above, have had any questions explained to my satisfaction and do herein expressly and voluntarily authorize disclosure of the above information about, or medical records of, my condition to those persons or agencies listed above.

______________________ ______________________
Signature of Patient ***Date***

____
Print ***Name***

When patient is a minor, or is not competent to give consent, the signature of a parent, guardian or other legal representative is required.

______________________ ______________________
Signature of Legal Representative ***Date***

______________________ ______________________
Print ***Name*** ***Relationship to Patient***