
MEDICAL RECORDS RELEASE

EXPLANATION: This form authorizes the use or disclosure of protected health information in the manner described below and is voluntary. Selma Carlson Diagnostic Center cannot condition services on whether or not you sign this authorization except under limited circumstances such as for services related to research, eligibility or enrollment determinations, or services performed solely to create information for an outside requestor (such as worker's compensation). In these circumstances, Selma Carlson Diagnostic Center may refuse services unless you provide an authorization for the disclosure of your information. **Please be aware that once your information leaves our Selma Carlson Diagnostic Center, Selma Carlson Diagnostic Center will no longer be able to protect that information, and the recipients of your information may not be legally required to protect your information.**

ADDITIONAL COPY: I further understand that I have a right to receive a copy of this authorization upon my request.

AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION

All sections of this authorization must be completely filled out before Selma Carlson Diagnostic Center is permitted to disclose your protected health information.

I request a copy of my records or authorize the release of information pertaining to medical history, mental or physical condition, services rendered, or treatment, as described below for:

Patient Name: _____ Also known as: _____

Date Of Birth: ____/____/____ Telephone: () _____

Please mail to: _____

Street Address	City	State	Zip
----------------	------	-------	-----

I will pick up on: (date) _____

Date of Service: From ____/____/____ to ____/____/____

Type of Information: _____ **Exam:** _____

Reports

I authorize the disclosure of medical records from to the following third party individual(s).

Name: _____ **Relationship to Patient:** _____

Name: _____ **Relationship to Patient:** _____

PLEASE NOTE: We are a film-less facility. Should your physician need a CD of the images we can provide that. Should you need a replacement copy there is a \$15 charge for CD's and a \$25 charge for Films.

Signed: _____ **Date:** _____

Printed Name: _____