MEDICAL IMAGING RELEASE AUTHORIZATION FORM
To Permit Use and Disclosure of Health Information

Mail this form with a **copy of your valid Photo ID AND your minimum $10 payment** for a single imaging study. You must pay for any additional requested studies at $8 per study **before processing can begin**. Once all items have been received, allow 15 days for processing & mailing.

Patient Name: _____ **Date of Birth:** _____

____ **I am either the patient named above**

____ **I am the patient's legally authorized healthcare representative**

By signing this form below, I am authorizing Carrell Clinic to use or disclose the requested imaging to:

My Name: _____

My Mailing Address: _____

_____

My Phone: _____

My Email Address: _____

I AM REQUESTING THE FOLLOWING IMAGING STUDIES (X-Rays, MRIs, etc.):
You must specify type of imaging study and date of study. Charge: $8 per study + postage/shipping

Type of Imaging: _____ Date: _____

Type of Imaging: _____ Date: _____

Type of Imaging: _____ Date: _____

Type of Imaging: _____ Date: _____

I understand that I may revoke the Authorization at any time, except to the extent that action has been taken in reliance on it (or unless this Authorization is given as a condition of obtaining insurance coverage and the insurer has certain legal rights to contest the policy or a claim under the policy). If I revoke this Authorization, I must do so in writing.

I understand that I may refuse to to sign this Authorization. I also understand that my treatment will not be conditioned on receiving my signature on this Authorization.

I have been informed and understand that information discussed pursuant to this Authorization may be subject to redisclosure by a recipient of such information. It is possible that once disclosed, the privacy of the information will not longer be protected under federal medical privacy law.

This Authorization expires automatically upon _____
Date or event that relates to the patient or purpose of the Authorization

_____
Signature of Patient or Legally Authorized Healthcare Representative

If Legally Authorized Healthcare Representative, explain authority to act on behalf of the patient:

_____