Elevation Medical
IMAGING

Medical Records Release

I authorize Elevation Medical Imaging the access and disclosure of my Protected Health Information (PHI) for billing, condition, treatment, and prognosis to the following individual(s)/parties listed below:

Name _____ Relationship _____

Name _____ Relationship _____

Name _____ Relationship _____

AND/OR

Provider/Organization:_____

Address: _____ City/State/Zip: _____

Phone:_____ Fax: _____

Records Requested: _____

I request the following restriction (s) to releasing my PHI:

I understand that I am entitled to a copy of Elevation Medical Imaging Notice of Privacy Practices. I can access a copy of the Notice of Privacy Practices from the office directly. I understand that I have the right to revoke this authorization, in writing, at any time. I understand that a revocation is not effective to the extent that any person or entity has already acted in reliance on my authorization or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim. Unless otherwise revoked this authorization shall be in force and effect one year from today's date at which time this authorization expires.

_____ _____

Signature of Patient Date

_____ _____

Signature of Parent/Guardian/Legal Power of Attorney Date