Mid West Imaging
MRI of Springfield

MRI of Springfield, INC. Authorization for Use and Disclosure of Protected Health Information

Printed Name: _____ DOB: _____

Social Security Number: _____ Phone Number: _____

Information to be Released Dates of Service From: _____to _____

MRI: _____Images: _____ Report: _____ CT: _____ Images: _____ Report: _____

Other: _____ Images: _____ Report: _____

Purpose of Request: Treatment _____ Patient Request _____ Billing/Claims _____ Other _____

I, Undersigned authorize and request MRI of Springfield to:

Obtain Information From: _____Phone/Fax Number: _____

Release Information To: _____ Phone/Fax Number: _____

Drug &/or Alcohol abuse, &/or Psychiatric, &/or HIV/AIDS Records Release:
I understand that my medical or billing record may contain information in reference to drug & alcohol abuse, psychiatric care, sexually transmitted Disease, Hepatitis B or C testing, HIV/AIDS testing &/or treatment, &/or other sensitive information & I agree to its release.

Time Limit & Right to Revoke Authorization:
Except to the extent that action has already been taken in reliance on this authorization, at any time I can revoke this authorization by submitting a notice in writing to the facility Privacy Officer at 1420 E. Bradford Parkway Springfield, Mo. 65804. Unless revoked, this authorization will expire 1 year from date of signature unless otherwise specified.

Re-Disclosure:
I understand that once information is released to the above-named person or persons, my information may be subject to disclosure. I understand that I do not have to sign this authorization, & my treatment or payment for services will not be denied if I do not sign this form unless it is for research related treatments or provided solely to give information as specified under purpose of Request. I can inspect or copy the protected health information specified above. I understand that if I authorize the release of Drug & Alcohol abuse treatment records, that those records are protected by Federal Law. The Authorization for release of information form does not authorize re-disclosure of medical records protected by this law from being re-disclosed even to the patient, without the specific written consent to the patient or otherwise permitted by such law &/or regulations. A general authorization for the release of medical or other information is not sufficient for these purposes. Federal rules restrict any use of the information for criminal investigation or prosecutions of any alcohol or drug abuse patient.

Printed Name of Patient: _____Date: _____

Signature of Patient or Patient Guardian: _____

Identity of Requester Verified via: Photo ID _____ Matching Signature _____ Other _____

Verified by: _____