CMI RELEASE OF PATIENT HEALTH INFORMATION (PHI)

TO SELF OR WHEN NOT FOR THE PURPOSE OF TREATMENT, BILLING FOR SERVICES OR HEALTHCARE OPERATIONS.

I hereby authorize the use of disclosure of my individually identifiable health information as described below. I understand that if my health information is used or disclosed as I am requesting, the released information may no longer be protected by privacy regulations issued by the federal government.

PATIENT NAME:_____DATE OF BIRTH:_____

SOCIAL SECURITY #:_____

I request that Cooperative Magnetic Imaging (CMI) release copies of my medical records to:

- o **Myself** or my personal representative.
- o **Other Persons** authorized to receive the information:

  Name:_____

  Address:_____

SPECIFIC DESCRIPTION OF INFORMATION TO BE RELEASED:

Dates of service/exam type:_____

Type of Information (circle all that apply): CD Report(s) Films

The patient or the patient's representative must read and initial the following statements:

- I understand that this authorization will expire 6 months from date of request. Initials:_____
- I understand that I may revoke this authorization at any time by notifying CMI in writing, but if I do revoke it, the revocation will not have any effect on any actions CMI took before it received the revocation. Intiials:_____

_____Date_____
Signature of patient or patient's representative

Printed name of patient or representative:_____

If representative, relationship to patient:_____

For CMI Office use:

O Released records as requested.
O Request denied due to one of the following- please check all that apply.

___Information was compiled for civil, criminal or administrative actions.
___Was not created or performed by this practice.
___Professional decision that this information may be harmful to the patient.

Request granted on:_____ Records copied and sent (date/initials)_____/____

Authorizing Signature:_____Date:_____

Request denial, patient notified by:_____Date:_____