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.	CD Payment (circle): Y or N If no, reason:_______________ Payment Type: (circle) Cash Check Credit Card **Payment Amount:**
Authorizing Signature:_________________________________Date:__________________ Records copied and sent (date/initials)_____/____ Request denial, patient notified by:______________________________Date:____________	