Community Health Network

(Patient Label)

Important Please Read: There is a fee for Films or Computer Discs (CD's) that are for "Personal Use Only." $10.00 per CD or $10.00 per page of film.

Patient Name: _____ Date of Birth: _____/_____/____ MRN:_____

Phone #: _____ Exam(s) Performed at: ☐ CHE ☐ CHN ☐ CHS ☐ Imaging Center ☐ TIHH

I authorize Community Hospitals to release my Medical Imaging Records for the purpose of this disclosure:

☐ Self

☐ Physician Name: _____ Address: _____

Phone: _____

☐ Other: _____ (Hospital, attorney, etc.)

If designating another person to retrieve, must provide name: _____

*Information to be released in form of: ☐ FILM ☐ *Computer Disc (CD)

*Report included on CD's and requires patient (guardian or custodian) signature.

INFORMATION TO BE DISCLOSED: Please indicate type(s) of exam(s) and list exam(s) and/or body part(s).

☐ CT ☐ MRI ☐ NUCLEAR MEDICINE ☐ RADIOLOGY ☐ ULTRASOUND

Exam: _____ Date of Exam: _____ Acct #: _____

Exam: _____ Date of Exam: _____ Acct #: _____

Exam: _____ Date of Exam: _____ Acct #: _____

Exam: _____ Date of Exam: _____ Acct #: _____

Exam: _____ Date of Exam: _____ Acct #: _____

Exam: _____ Date of Exam: _____ Acct #: _____

- I hereby voluntarily authorize and consent to disclosure of health records and/or information as stated below.
- I understand that I may refuse to sign this authorization, and that my refusal will not affect my ability to obtain services, treatment or payment for services; unless services provided are solely to create health records for a third party, such as physical and drug testing for an employer or insurance company; or if treatment provided is research related and authorizations is required for the use of health information for research purposes.
- I understand that I may see and copy the information described in this form if I ask for it.
- Unless limited below, I understand that this release also pertains to records whose confidentiality is protected by either Federal Regulations (42 CFR Part 2) or State Law (IC 16-39-2) concerning hospitalization or treatment, including but not limited to, information regarding treatment and related services for alcohol and/or substance abuse, communicable disease documentation, human immunodeficiency virus (HIV) or for mental health treatment or counseling.

I understand that this authorization is voluntary and that I have the right to revoke it, at any time, prior to its expiration date by written notification to the Medical Imaging Department. This revocation will not have any effect on the information released pursuant to this Authorization before the revocation. I understand that the information released may be subject to re-disclosure by any recipient and no longer protected by federal privacy laws. **Expiration Date is 30 days from request.**

X_____ ____/____/___ _____ _____/_____/_____

Patient Signature (Date) Parent/Guardian (if child under 18 yrs) (Date)

Power of attorney documentation must be provided by custodian if applicable. (Copy and attach.)

X _____ ___/___/___ # _____

Designee's Signature (spouse, family, friend) (Date) Drivers License Number

X_____ ___/___/___

Witness Signature (Date)

Initials of Staff taking Phone request: _____

Released by Imaging Staff (Initials): _____ Date: _____

18315 02/11/13