Advanced Imaging Centers | Ocala Health

AUTHORIZATION OF PROTECTED HEALTH INFORMATION RELEASE

REQUEST FROM:

_____
Name of Facility

_____
Street Address City State Zip Code

_____ _____
Phone Number Fax Number

****

PATIENT INFORMATION:

_____
LAST NAME, FIRST NAME DATE OF BIRTH

_____
LAST 4 DIGITS SSN PHONE NUMBER

INFORMATION REQUESTED:

Please send a **DICOM** CD/FILMS and a REPORT for: _____
Type of Exam(s)

*****If available, please send through Nuance POWERSHARE to HCA North Florida*****

Approximate date(s) of service: _____

Purpose of Disclosure: Study comparison; Continuity of patient care.

Unless otherwise revoked, this Authorization will expire on the following date, event, or condition: INDEFINITE

Please send records to: Advanced Imaging Centers
Attn: Medical Records
2300 SE 17th Street, Suite 301
Ocala, FL 34471
Phone: 352-867-9606 (opt. 3) Fax: 352-867-1565

AUTHORIZATION: I authorize the above-named healthcare provider to disclose the requested medical information to the organization named on this request. I acknowledge, and hereby consent to such, that the released information may contain alcohol, drug abuse, genetic information, psychiatric, HIV testing/results, or AIDS information.
I certify that this request was made voluntarily, and that I may refuse to sign. My treatment, payment, enrollment or eligibility for benefits may not be conditioned on signing this authorization. I understand that I may revoke this authorization at any time in writing by sending a letter to the facility Privacy Officer or their designee. I understand that the revocation will not have any effect on any actions taken prior to receiving the revocation.
If the requester is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations and may be re-disclosed. I understand that I may see and obtain a copy of the information described on this form, and a reasonable copy fee may be charged. I understand that I may have a copy of the signed authorization form.

_____ _____
PATIENT/AUTHORIZED REP. SIGNATURE DATE

***Please note the first CD provided to the patient is complimentary.**
***Patient will be charged $5 for each subsequent CD of the same exam(s).**