Record Release Authorization Form

Date: _____

To Gateway Radiology:

Please release my radiology records to _____.
Print the name of person you want your records released to

All records _____ Specific records_____

If you have any questions, I can be reached at _____.
Your Telephone number

I have reviewed the complete HIPAA compliant release form information on gatewayradiology.com. I am the patient and I understand and agree to the provisions of this authorization.

I understand and acknowledge the following statements:

1. I may revoke this authorization at any time by notifying the Provider in writing of the revocation, unless the Provider has already relied on this authorization to disclose PHI;
2. PHI disclosed may be subject to re-disclosure and no longer be protected by federal or state privacy laws;
3. I am signing this authorization voluntarily. I may decline to sign this authorization. However, refusal to sign does not stop the Provider's disclosure of PHI that is otherwise permitted to be disclosed by law without my specific authorization;
4. I understand that unless otherwise revoked, this authorization will expire one year after the patient is discharged from Provider's care.

_____ _____

Print your name **Sign** your name

_____

Your date of birth

All information above must be filled in and legible in order for this release to be valid. The person you designate to pick up your records must present a state issued picture ID.