ORLANDO HEALTH® | Imaging Centers

LINE UP PATIENT I.D. LABEL HERE

ALTAMONTE / DOWNTOWN ORLANDO / SPRING LAKE / OCOEE / SANFORD
Phone: 407-331-9355 Fax: 407-331-9481

To authorize Orlando Health Imaging Centers to release your reports and/or films, complete Part I of this form. To authorize Orlando Health Imaging Centers to obtain copies of reports and/or films from a previous provider, complete Part II of this form.

PART I. AUTHORIZATION FOR RELEASE OF REPORTS AND/OR FILMS

Date: _____ Account No.: _____

Patient's Name: _____ SSN#: _____ - _____ - _____

Address: _____
City State Zip Code

Phone: _____
Home Phone Cell Phone Work Phone

Date of Birth: _____ Male _____ Female _____

Exam Type: _____

Exam Date: _____

By signing this form, I authorize the use and disclosure:

From Whom: OHRI, LLC d/b/a Orlando Health Imaging Centers

Of the following information (initial next to all that you want disclosed):

___ Radiology Reports and Images
___ Physicians' Orders
___ Other (please specify):_____

Note: Information created before or after the date of this form may be disclosed, unless you specify a date range of records here: From (mm/dd/yyyy) _____ To (mm/dd/yyyy) _____.

To Whom:
Person/Organization Name:_____ Phone: _____
Address: _____ Fax:_____

Purpose (check all that apply):
___ My medical treatment and related services and products
___ Payment
___ Personal use
___ Other (please specify: _____

Effective Period: This authorization will remain in effect until (check one):
___ The day I withdraw my permission or the date of my death
___ A specific date (mm/dd/yyyy): _____
___ A specific event. Please specify:_____

If I fail to specify an expiration event or condition, the authorization will expire in one year.

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I understand that this authorization is revocable upon written notice to Orlando Health Imaging Centers, except to the extent that action has already been taken on this authorization. I understand that my protected health information that is used or disclosed under this authorization may be subject to re-disclosure by the recipient and the privacy of my protected health information may no longer be protected by law. I further understand that my choice on whether to sign this form will not affect my ability to get medical treatment, payment for medical treatment, or health insurance enrollment or eligibility for benefits.

Orlando Health Imaging Centers releases one complimentary copy. Each additional copy will be $10.00

Authorized individuals who may pick up records:_____

_____ _____ _____

Patient (Parent/Guardian/Representative) Signature Date Time

Relationship to Patient: _____

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PART II. OUTSIDE FILM REQUEST:

Date: _____ Account No.: _____

Patient's Name: _____ SSN#: _____ - _____ - _____

Address: _____
City State Zip Code

Phone: _____
Home Phone Cell Phone Work Phone

Date of Birth: _____ Male _____ Female _____

Exam Type: _____

By signing this form, I authorize the use and disclosure:

From Whom: (name of previous facility/hospital)

_____

_____

_____

Of the following information (initial next to all that you want disclosed):

___ Radiology Reports and Images
___ Physicians' Orders
___ Other (please specify):_____

Note: Information created before or after the date of this form may be disclosed, unless you specify a date range of records here: From (mm/dd/yyyy) _____ To (mm/dd/yyyy) _____.

To Whom: **OHRI, LLC d/b/a Orlando Health Imaging Centers**
Address: _____ Phone: _____
_____ Fax: _____

Purpose (check all that apply):

___ My medical treatment and related services and products
___ Payment
___ Personal use
___ Other (please specify: _____

Effective Period: This authorization will remain in effect until (check one):

___ The day I withdraw my permission or the date of my death
___ A specific date (mm/dd/yyyy): _____
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If I fail to specify an expiration event or condition, the authorization will expire in one year.

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I understand that this authorization is revocable upon written notice to the above-named provider, except to the extent that action has already been taken on this authorization. I understand that my protected health information that is used or disclosed under this authorization may be subject to re-disclosure by the recipient and the privacy of my protected health information may no longer be protected by law. I further understand that my choice on whether to sign this form will not affect my ability to get medical treatment, payment for medical treatment, or health insurance enrollment or eligibility for benefits.

_____ _____ _____

Patient (Parent/Guardian/Representative) Signature Date Time

Relationship to Patient: _____