SimonMed™
See Tomorrow Today

Authorization to Release Protected Health Information

PLEASE FILL OUT EACH SECTION BELOW

PATIENT NAME: _____ MRN: _____

DATE OF BIRTH: _____ SOCIAL SECURITY NUMBER: X X X – X X – ____ ____ ____ ____

ALIAS/MAIDEN NAMES: _____ Phone: _____

To Disclose My Records: (Please check the exam(s) for which you are requesting reports/images)

- ☐ All Medical Records
- ☐ MRI
- ☐ PET
- ☐ CT
- ☐ X-Ray
- ☐ Dexa / Bone Densitometry
- ☐ Sonogram/Ultrasound
- ☐ Mammogram
- ☐ Nuclear Medicine
- ☐ Other: _____

Please provide a description of the exam you are requesting reports/films on (date, exam, body part):

_____

Are you requesting (check all that apply)**:** ☐ Report(s) ☐ CD ☐ Films

Please note, a $25.00 fee per set of films will apply. All films and CDs are promptly prepared at the time of pick up.

Please indicate how you would like these to be received:

☐ Fax to: _____ ATTN: _____

☐ Mail to: _____

☐ Email to: _____

☐ Collect in Person: *I understand that my records will only be provided to myself or any individual(s) I listed below. A photo ID is required at the time of pick up.*

By my signature below, I authorize SimonMed Imaging to release my protected health information to the following individual(s):

Name: _____ Relationship: _____

Name: _____ Relationship: _____

I understand that after the custodian of records discloses my health information, it may no longer be protected by federal and/or state privacy laws. I further understand that this authorization is voluntary and that I may refuse to sign this authorization. My refusal to sign will not affect my ability to obtain treatment, payment, eligibility for benefits unless allowed by law. I understand this authorization may be revoked in writing at any time, except to the extent that action has been taken in reliance on the authorization. Unless otherwise revoked, this authorization will expire 1 year from date of signature. *You have the right to revoke this authorization, except to the extent the custodian of records has relied on it, by sending your written request to the Privacy Officer at: 6900 E. Camelback Road, #700 Scottsdale, AZ 85251*

_____ _____

Patient or Authorized Representative Signature | Date of Signature

_____ _____

Printed Name of Patient or Authorized Representative | Relationship to Patient

Phone: (866) 614-8555 Fax: (602) 302-5958