RAA
RADIOLOGY ASSOCIATES
OF ALBUQUERQUE, PA

HIGH RESOLUTION
OUR FOCUS IS YOUR HEALTH

Release of Information Form

Medical Records Department
RAA/Advanced Imaging LLC
4411 The 25 Way NE, Suite 150, Albuquerque, NM 87109
Phone: (505) 332-5842   Fax: (505) 332-5887

Patient Name: _____ Date of Birth _____

ALIAS/MAIDEN NAMES_____

I hereby authorize Advanced Imaging LLC/RAA to obtain medical records from any provider, without limitation, including the following:

Facility/Entity _____ Address_____

Reason for Request: Continuing Care of Patient _____

Description of protected health information requested:

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PLEASE FAX REPORTS TO
PLEASE MAIL CD/FILMS TO:

- This authorization expires 1 year after date of signature unless otherwise specified.
- I understand that I have the right to revoke this authorization at any time by sending a written request to High Resolution. However, I understand that any action already taken in reliance on this authorization cannot be reversed, and my revocation will not affect those actions.
- I understand that the information released may be subject to re-disclosure by some recipients and may no longer by protected by federal and state privacy rules related to health information.

_____   _____
Signature of Individual   Date of Signature

_____   _____
Signature of Patient Representative   Relationship to Patient

_____   _____
Printed Name of Patient Representative   Date of Signature

A signed medical release is not required from the patient pursuant to HIPAA regulation standard 45 CFR 164.506 (c)(2) "A covered entity may without the individual's authorization disclose protected health information for the treatment activities of a healthcare provider."