Release of Information Form

NOTICE TO RECIPIENT: This Facsimile may contain Protected Health Information which is protected under HIPAA and State Laws. If you are not the intended recipient of this facsimile you are prohibited from sharing, copying, or otherwise using or disclosing its contents. If you have received this facsimile in error, please notify the sender immediately by either calling, or faxing a notification of the error. Please securely dispose or shred the facsimile without reading, copying or saving. Thank you.

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 RAA/Advanced Imaging LLC to release medical records to any provider, without limitation, including the following:

Facility/Entity _____ Address_____

Reason for Request: Continuing Care of Patient_____

Description of protected health information requested:

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."