AUTHORIZATION TO RELEASE RECORDS

NorthStar RADIOLOGY

Patient First & Last Name: _____

Date of Birth: _____/_____/_____ **Social Security Number**: _____ – _____ – _____

I hereby request and authorize **North Star Radiology** to release health care information of my imaging report(s) of the patient named above to the following entity or person:

Organization / Person Name: _____

Address: _____

City: _____ **State**: _____ **Zip Code**: _____

This request and authorization applies to the following: (please check all applicable boxes):

- ☐ **All health care information**
- ☐ **Health care information relating to the following treatment, condition, or dates of treatment**:

  _____
- ☐ **Other**: _____

By initialing any of the boxes which apply below, I specifically authorize the release of the following records:

☐ HIV/AIDS ☐ Mental health ☐ Sexually transmitted diseases ☐ Drug and/or alcohol use

Patient Signature: _____ **Date**: _____ / _____ / _____

CONSENT OF GUARDIAN OR AUTHORIZED PERSON

First & Last Name: _____

Signature: _____

Date: _____ / _____ /_____ **Relationship to Patient**: _____

NOTICE: North Star Radiology is also pleased to provide complimentary copies of your health care information directly to your health care provider. Authorization becomes invalid ninety (90) days after this form was signed, or upon the expiration date of: _____ / _____ /_____, whichever is earlier.

DISCLAIMER: If a minor consented to health care without parental consent for his/her own treatments, the minor must consent or release his/her own records. North Star Radiology is hereby released from all legal responsibility of liability from the release of the above-mentioned information. Once disclosed, the law does not always require the recipient of your information to maintain the confidentiality of your health care information. You are entitled to a copy of the authorization. You may revoke this authorization by written request. If you have any questions about disclosure of your health information, please contact North Star Radiology.

FOR INTERNAL USE ONLY

☐ Identification checked?

Staff Initials: _____

1.19.2018

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