Inland Imaging®

AUTHORIZATION TO USE AND DISCLOSE PROTECTED HEALTH INFORMATION

I authorize Inland Imaging, LLC to release the specified protected health information described below:

Information to be released:

☐ All Medical Records ☑ Records for date(s) specified: _____

To be disclosed to:

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

For the purpose of:

☑ Transfer of records to another provider

☐ Legal action/Attorney use

☐ Personal use

☐ Other (specify)

This authorization expires on:

Date: _____ Or event: _____

Patient Name: _____ DOB: _____

(Please print)

Signature of Patient _____ Date: _____

Signature of Patient's representative: _____ Date: _____

Relationship to patient: _____

You have the right to revoke this authorization at any time, provided that you do so in writing. Revoking this authorization does not apply to information already used or disclosed by this authorization.

I hereby revoke this authorization.

Name of individual or personal representative: _____

(Please print)

Signature of individual or personal representative: _____ Date: _____

This form is not valid if not filled out completely. A copy of this form may be used in the same manner as the original.

Fax completed form to 509.232.6130 **OR** email signed copy to *PatientServicesRequests@inlandimaging.com*. For more info, call 509.747.4455.