BONITA COMMUNITY HEALTH CENTER

RADIOLOGY

Patient/Representative Access to Protected Health Information

3501 Health Center Blvd, Bonita Springs Fl 34135
Tel 239-949-6105 Fax 239-949-6125

Pursuant to the Health Insurance Portability and Accountability Act (HIPAA), I hereby authorize the Radiology Department of Bonita Community Health Center to disclose the following information from the Radiology records of:

_____ _____
Patient's Full Name **Phone number**

Date of Birth_____/_____/_____ Patient Medical Record #_____

Radiology exam date(s) of service: _____ to _____

Radiology information to be disclosed: **□CD or □ Secure email**

MRI _____ Ultrasound _____ CT Scan _____ Mammogram _____ X-ray _____

This information is to be disclosed to _____
Physician or Patient's name

_____
Address City/State Zip Code

_____
Phone Number and Email Address **(required for virtual imaging requests/print clearly)**

According to the Privacy Notice, I understand that this authorization may be revoked in writing at anytime, except to the extent that action has been taken in reliance on this authorization. I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law. Unless otherwise revoked, this authorization will expire in 90 days. The facility, its employees, officers, and physicians are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein.

_____ ____/____/_____
Signature of Patient/Legal Representative Date

_____ ____/____/_____
Signature of Witness Date

ALL CD REQUEST WILL BE CONFIRMED WITH THE PHYSICIAN'S OFFICE.
THERE WILL BE A CHARGE OF $5.00 ($6.50 TO MAIL THE CD) FOR ANY CD'S NOT REQUESTED BY A PHYSICIAN'S OFFICE.

For internal use only: **Patient Paid: _____** **CD Made: _____Date/Initials**

Patient Picked up **Mailed to Physician** **Emailed: _____ Date/Initials**