Authorization for Release of Protected Health Information

Patient Name: (Maiden/Other Name):

Patient Date of Birth: Phone #:

I hereby authorize the following facility to release all requested operative reports, radiology images and associated reports to PENRAD Imaging for continued healthcare.

Facility Information: (Where procedure(s) or images were performed)

Facility Name:
Facility address:
City: State: Zip:
Telephone #: Fax #:

Need by/Appointment date:

I understand that this Authorization is effective for a period of 90 days from the date of signature, unless otherwise specified below. No time frame may exceed one year from the date of signature. I understand I have the right to revoke this authorization at any time by sending a written request to the entity/person I authorized to release the information. If applicable, specify any other expiration date / event here: _____

_____ _____ _____
Signature of Patient Date of Signature Signature of Parent or Guardian

Please release the protected health information to:

PENRAD Imaging
3050 N Circle Dr. Colorado Springs, CO 80909
Phone: (719) 867-7962 Fax: (719) 867-7915