



SUMMIT
radiology

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

NAME _____

BIRTHDATE _____ Social Security # _____

I understand that as part of my healthcare, this organization originates and maintains health records describing my health history, symptoms, examination, and test results, diagnosis, treatment, and any plans for future care or treatment.

I understand that this information serves as:

- A basis for planning my care and treatment
- A means of communication among the many healthcare professionals who contribute to my care.
- A source of information for applying my diagnosis and surgical information to my bill.
- A means by which a third-party payer can verify that services billed were actually provided.
- A tool for routine healthcare operations such as assessing care quality and reviewing the competence of healthcare professionals.

I understand that I have the right:

- To request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or healthcare operations.
- To revoke this consent in writing, except to the extent that the organization has already taken action in reference thereof.

I request the following restrictions to the use or disclosure of my health information:

PATIENT:

X _____ Date
Signature of Patient or Legal Representative