DIAGNOSTIC IMAGING NORTHWEST

An Alliance of Medical Imaging Northwest & MultiCare Good Samaritan Hospital

MEDICAL RECORDS AUTHORIZATION FORM

Patient Name _____ **Previous Name(s)** _____

Date of Birth _____ **Phone Number** _____

SSN (last 4 digits) _____

Street Address _____

City _____ **State** _____ **Zip** _____

I. I hereby voluntarily authorize the disclosure of information from my health record.

II. **The Information is to be provided to:**

Name of Person (or designate) / Organization / Facility: _____

Address _____

City _____ State _____ Zip _____

I would like my records:

☐ Mailed to the address listed above

☐ Faxed to: _____

☐ I (or my designate) will pick up at the following Diagnostic Imaging Northwest location:

☐ Bonney Lake Imaging Center
21110 SR 410E Ste 110, Bonney Lake, WA 98391

☐ Puyallup Imaging Center
222 15th Ave SE, Puyallup, WA 98372

☐ Sunrise Imaging Center
11212 Sunrise Blvd. E. Ste 200, Puyallup, WA 98374

III. **The Purpose or need for this disclosure is:**

☐ Personal Use ☐ Further Medical Care ☐ Attorney

☐ Other (specify): _____

IV. **The information to be disclosed from my health record: [check appropriate box(s)]**

☐ Only information related to (specify): _____

☐ Only the period of events from _____ to _____

☐ Other (specify): _____

Please check all that apply:

☐ Entire Record ☐ Radiology Report ☐ *Radiology Images: ☐ (CD) or ☐ (film)

**Note: charges may apply for copies of Radiology Images (printed to film only).*

V. Term of authorization: This authorization is valid for a period of 90 days from the time of signature.

VI. I understand that I may revoke this authorization in writing submitted at any time to Diagnostic Imaging Northwest, except to the extent that action has been taken in reliance on this authorization.

VII. My Rights: I understand I do not have to sign this authorization in order to get health care benefits (treatment, payment, or enrollment).

VIII. Disclaimer and Costs: If Diagnostic Imaging Northwest releases radiographic films in proper condition, we are absolved of any and all liability pertaining to the retention of the x-ray films until they are returned in a safe manner and in proper condition. In the event Diagnostic Imaging Northwest furnishes copies of radiographic films and/or reports, the patient or responsible party agrees to be responsible for the expense as provided for in the Uniform Health Care Information Act of 1991.

IX. I understand that information disclosed by this authorization, may be subject to re-disclosure by the recipient and may no longer be protected by the Health Insurance Portability and Accountability Act Privacy Rule.

_____ _____

Patient or legally authorized individual signature **Date**

_____ _____

Printed name if signed on behalf of the patient **Relationship (parent, legal guardian, personal representative)**

Please return this form via fax: (253) 845-3680; or mail to: Diagnostic Imaging Northwest, Attn: Medical Records, 1201 Pacific Ave, Suite 400, Tacoma WA 98402; or bring with you to any Diagnostic Imaging Northwest location.