MT BAKER IMAGING and
NORTHWEST RADIOLOGISTS

Authorization to Use and Disclose Health Information

Patient

Patient Name: _____ **Birth Date:** _____

Maiden or Previous Name: _____ **SSN:** _____

From

I authorize:

☐ **Mt Baker Imaging** **OR**

2930 Squalicum Parkway, Suite 101
Bellingham, WA 98225
Phone: 360-733-0430 x4038
Fax: 888-329-6768

☐ **Prior Imaging Facility (name/address of disclosing entity):**

Company:

Address:

City, State, Zip:

Phone: **Fax:**

To use and/or disclose a copy of the health information described below for the above-named patient.

To

Health information is to be received and used by:

☐ **Mt Baker Imaging** **OR**

2930 Squalicum Parkway, Suite 101
Bellingham, WA 98225
Phone: 360-733-0430 x4038
Fax: 888-329-6768

☐ **Physician/Imaging Facility (name/address of disclosing entity):**

Company:

Address:

City, State Zip:

Phone: **Fax:**

Exams Requested

Exams Requested:

Exam: _____ **Date:** _____

Exam: _____ **Date:** _____

Exam: _____ **Date:** _____

Date Images needed by: _____

CD or eMix check one: ☐ CD (Number of CD's Needed____) ☐ eMix

Purpose or need for disclosure. (Please check applicable categories)

☐ Medical purposes (no fee) ☐ Patient use (fee $25.00 per CD)
☐ Paid Fee ☐ Pay date of pick-up

☐ Pick up images ☐ Mail to the above named facility

☐ Request made in person ☐ Request made by phone

CD being used on a Mac computer? _____

Notices

1. I may refuse to sign this authorization. My refusal will not adversely affect my ability to receive treatment, to enroll in a health plan, to be eligible for benefits, or to obtain payment for services unless this authorization is sought for purposes of research related treatment, to determine my eligibility or enrollment in a plan, for underwriting or risk determinations or if the services related to the information to be disclosed are performed solely for the purpose of providing that information to someone else.
2. I may revoke this authorization at any time by notifying the Health Information Management/Medical Records Department of the above named entity on its designated form. However, any such revocation will not apply to any activity undertaken based on this authorization.

Dates

Unless revoked, this authorization is valid for 90 days from the signature date below, or for the following time period:

Beginning date: _____ **to** Ending (expiration) date: _____

Signature

SIGNATURE: I have read this authorization, and I understand it.

_____ _____
Signature of Patient or legal/personal representative **Date**

If being picked up by someone other than myself, I authorize the release of my Protected Health Information (CD/Films) to the following individual:

Name: _____ **Relationship:** _____ **Patient Signature:** _____

For Mt Baker Imaging Centers Use Only: **Employee requesting:** _____ **Employee Ext.** _____

Date Received: _____ **MI#** _____ **MRN:**_____

☐ **Records sent by:** _____ **Date:** _____