Authorization for Release of Radiologic Films

2412 Ring Road, Suite 200 ~ Elizabethtown, KY 42701
Phone: (270) 765-5926 Fax: (270) 763-0051

Patient Name: _____

Date of Birth: _____ SS#: _____

Phone: _____

I request that Heartland Primary Care release the following x-ray films to me:

X-Ray Film	Date of Exam
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Where the films going? _____

This authorization will expire 30 (thirty) days from the date of signature unless revoked or terminated by the patient or the patient's personal representative. It is understood that my x-ray records may not be released to me at the same time as requested. I may revoke or terminate this authorization by contacting the x-ray department. I understand, however, that revocation will not apply to information that has already been released in response to this authorization.

I understand that if the person(s) or entity that receives this information is not a health care provider or health plan covered by the Health Insurance Portability and Accountability Act of 1996 (HIPAA), the information described above may be disclosed and is no longer protected by those regulations. Therefore, I release Heartland Primary Care, its employees and providers, from all liability arising from this disclosure of health information.

I understand that I am entitled to ONE FREE COPY of each x-ray film during my lifetime. This copy will be provided on a compact disc (CD). Any additional copies needed for any reason are subject to a fee of ***$5 per compact disc (CD).***

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Patient Signature or Legal Representative Relationship to Patient Date