New England PET Imaging System

AUTHORIZATION TO USE OR DISCLOSE HEALTH INFORMATION

*I authorize New England PET Imaging System to use and disclose a copy of the specific health and medical information described below for:

_____ _____
(Patient Name) (Maiden or Prior Names)

_____ _____
(Date of Birth) (Phone # you can be reached)

Please Circle Type of Requested Record:

PET/CT Report PET/CT Images ☐ Disc ☐ Powershare CT Report CT Images ☐ Disc ☐ Powershare Billing

RELEASE Medical Records FROM: _____

Facility Phone # _____ Facility Fax # _____

RELEASE Medical Records TO: _____
(Person/facility)

_____ _____ _____ _____
(Address) (City) (State) (Zip)

_____ _____
(Phone #) (Fax #)

Release records for the purpose of:

Continuity of Medical Care Legal Personal (at my request)

AUTHORIZATION TO REQUEST AND USE INFORMATION

I understand I may revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to NE PET. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. **Unless otherwise revoked, this authorization will expire on the following date: _____. If I fail to specify an expiration date this authorization will expire 1 year from the date signed.** I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form to assure treatment. I understand I may inspect or obtain a copy of the information to be used or disclosed, as provided in CFR 164.524. If I have questions about disclosure of my health information, I can contact the authorized individual or organization making disclosure. I have read the above and do hereby acknowledge that I am familiar with and fully understand the terms and conditions of this authorization.

_____ _____
Signature of Patient/Parent/Guardian or Authorized Representative Date
(Guardian or Authorized Representative must attach documentation of such status.)

Office use only: **MRN# _____**
PLEASE PLACE COPY IN PATIENTS CHART AND PROVIDE PATIENT A COPY.

NOTES: