
AUTHORIZATION FOR ACCESS BY OTHERS TO YOUR PROTECTED HEALTH INFORMATION (PHI)

The Health Insurance Portability and Accountability Act (HIPAA) provides for the protection of your health records. We have instituted various policies and procedures that demonstrate our efforts and responsibilities to comply with this requirement. However, there may be occasions where you, the patient, may find it necessary to have others access, pick up or exchange your medical information due to various circumstances. When such situations arise, in order to expedite the releasing of your records or completing the billing process of your claims, you may provide a list below of individuals who you would authorize to receive/release this information on your behalf.

Please list individuals for whom your authorize access to your PHI:

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

ACKNOWLEDGEMENT: I understand the requirements of HIPAA and hereby authorize the release of my health records to the individual (s) indicated above. I understand that each individual I have listed will be required to: 1) provide information 2) present identification 3) sign required documents for release of my information. I also understand the center reserves the right to deny access.

Signature of Patient or Patient Representative **Date of Authorization**

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I certify I have been offered and/or received a copy of Open MRI of Frederick's Notice of Privacy Practices.

Signature of Patient or Patient Representative **Date**

INSURANCE AUTHORIZATION AND CONSENT

I certify that the information provided is correct. I authorize Open MRI of Frederick to furnish information to any Insurance Carrier concerning any illness, testing and treatments. I request that payment of authorized benefits e made in my behalf. I hereby assign the payments for service to Open MRI of Frederick or authorize Open MRI of Frederick to submit a claim to Medicare or other Insurance carrier for payment. I understand I am financially responsible for any amounts not covered by my health insurance.

Signature of Patient or Patient Representative **Date**
