



AUTHORIZATION TO RELEASE MEDICAL RECORDS

(DISCLOSURE OF PROTECTED HEALTH INFORMATION)

I understand that under the Health Insurance Portability Act (HIPAA), I have certain rights to privacy regarding my protected health information (PHI). I acknowledge that I have received or have been given the opportunity to receive a copy of your Notice of Privacy Practices which provides a more complete description of such uses and disclosures. I also understand that this practice has the right to change its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained and forwarded with a written request to Durango Ultrasound, LLC at 270 E. 8th Ave., Ste 204, Durango, CO 81301.

Acknowledgement of privacy practices:

Name: _____ date: _____

Patient Signature: _____

Medical release:

I hereby give Durango Ultrasound permission to obtain the following information for the purpose of comparison to previous exams and exam correlation. I understand I have the right to revoke this authorization in writing to the above address.

Requested information:

Radiology report/images

Laboratory/Pathology results

Office notes

Durango Ultrasound Exam

Have you had a previous imaging study (CT, MRI or ultrasound) of the same area that we are scanning today? If yes, what type of study, what facility/provider and the date of exam.

Study type: _____ Facility: _____

Name of provider: _____ Date of exam: _____

Request for copy of Durango Ultrasound exam:

Date of exam: _____ Facility/provider to send exam to: _____

Address of facility or provider: _____

Phone/fax#: _____ Email: _____

Your signature: _____ date: _____