CARETRACKER ACCT#_____

Boulder MRI

Patient's name _____ **DOB** _____

□ **Release from** □ **Release to**

□ **Boulder MRI, LLC, 1000 W South Boulder Rd, Suite 105, Lafayette, CO 80026**

□ **Patient**

□**OTHER** _____

□ **Release from** □ **Release to**

□ **Boulder MRI, LLC, 1000 W South Boulder Rd, Suite 105, Lafayette, CO 80026**

□ **Patient**

□**OTHER** _____

GENERAL AUTHORIZATION: I authorize the above-named health care provider to release the information specified below to the organization agency, or individual named on this request. Method of release shall be pertinent to the need and may include photocopies, fax copies, personal review, audio, video, electronic, or verbal communication by appropriate practitioner. I understand that BCH may not refuse to provide treatment if I refuse to sign this authorization, unless this authorization is necessary to participate in a research study or if the purpose of the treatment is to provide information to the party listed in this authorization. I understand that except for drug and alcohol treatment records, information disclosed under this authorization may be re-disclosed by the recipient and is no longer protected by privacy laws.

INFORMATION REQUESTED:

□ Complete copy of medical record
□ Imaging Reports
□ Physician's orders
□ CD
□ Other: _____

CONDITIONS AND DATES OF CARE COVERED:

□ Regarding these treatment dates and/or for conditions: _____
□ All admissions or care at this facility provided as of the date of my signature.

PURPOSE(S) FOR WHICH INFORMATION IS TO BE USED:

□ Further eval / treatment □ Insurance / reimbursement □ Legal □ Verify Treatment Status □ Personal use
□ Worker's Compensation □ Other (specify) _____

EXPIRATION OR REVOCATION OF AUTHORIZATION

I understand that I may revoke this authorization at any time, except to the extent that action has already been taken to comply with it. Without my previous expressed revocation, this authorization will automatically expire 90 days from the date of my signature unless noted below.

□ On _____ □ No longer than _____ days from the date of my signature or under the following conditions: _____
□ Upon fulfilling the purpose or need for information as specified above, but no longer than _____ days from the date of my signature.

NOTE: Federal regulations require consent to release alcohol or drug records last no longer than reasonably necessary to serve the purpose for which the release is given.

SIGNATURE: A copy of this authorization (including a facsimile copy) may be used with the same effectiveness as the original.

Patient's signature _____ **Date** _____

Authorized representative name (please print) _____ Relationship to patient _____

Authorized representative signature _____ Date _____

Witness _____ **Date** _____