Release of Information Authorization

Patient Name: ____ **Date of Birth:** _________________
MRN: ______________________________ **Phone Number:** ________________________________

I. Authorization
VRC may use or disclose the following health care information (check all that apply):

- ☐ All health care information in my medical record
- ☐ Health care information in my medical record relating to the following treatment or condition: ____
- ☐ Health care information in my medical record for the date(s): _______________________

VRC may disclose this health information to and/or receive health information from:

- ☐ All Imaging Clinics
- ☐ Another person(s): ____
- ☐ Specific Imaging Clinics: ____ ____

II. I request that the copy be provided:

- ☐ CD
- ☐ By unencrypted email to (report only; images cannot be emailed): ____
- ☐ Electronically through image sharing (if available):
- ☐ By other electronic mean (if agreed upon by VRC medical records department): ____

III. My Rights
I understand that:

- This Authorization is voluntary. My treatment will not be impacted, no matter if I sign this Authorization or not.
- This Authorization is valid for one year from date signed, unless I revoke/withdraw this Authorization, or unless an earlier date is specified here: ____________________. I may revoke/withdraw this Authorization, except to the extent that action has been taken prior to the receipt of the revocation/withdrawal, by mailing or faxing my written request along with a copy of the original Authorization to:

  Valley Radiology Consultants
  15725 Pomerado Rd Ste 101
  Poway, Ca 92064

Signature of Patient: ____ **Date:** _______________

If you are NOT the patient but are signing on behalf of the patient, please complete below:
I, ____, am the (check which applies)

☐ Parent with Parental Rights	☐ Registered Kinship Care Relative
☐ Court Appointed Guardian	☐ Legally Appointed Healthcare Agent
☐ Medical Power of Attorney	☐ Power of Attorney with Right to See Medical Records

Representative's Signature: ____ **Date:** _______________

If picking up records:
Name: ____**Date:** _______________________

Signature: ____