Steinberg Diagnostic
Medical Imaging Centers
"Where Imaging Revolves Around You"℠

RECORD RELEASE TO A THIRD PARTY

Patient Name: _____ **Date of Birth:** _____

I understand by signing below I am authorizing Steinberg Diagnostic Medical Imaging (SDMI) to disclose my protected health information as described to the recipients listed below. I understand and agree that this authorization is voluntary and I may refuse to sign this Authorization. I further understand that my treatment will not be affected if I do not sign this form. I understand that when the information is used or disclosed, pursuant to this authorization, it may be subject to re-disclosure by the recipient and may no longer be protected by the Federal HIPAA privacy rule.

□ Test Results only
□ Complete Medical Record
□ Date Specific Portions of my medical record From:_____ To: _____

In accordance to the Final Omnibus Rule 2013, I need to provide the following info:

Please release my records to:

Name of Person/Facility: _____

Address: _____

□ Mail Third Party a copy of my records to the above address

□ Third Party will pick up records

I release SDMI and its agents, representatives, employees from any and all liability associated with the release of confidential patient information in accord with this Consent. I understand SDMI cannot be responsible for use or re-disclosure of information to third parties.

_____
Print Name and Relation to Patient

_____ _____
Patient/Other Legally Authorized Person Signature Date

Office Use Only: MRN_____