



949 N Curtis Rd.  
Boise, ID 83706

Phone: (208)947-7002 or (800)657-6674  
Fax: (208)947-7001 or (800)657-6410

**AUTHORIZATION FOR RELEASE OF INFORMATION**

**Section A: Must be completed for all authorizations**

I, \_\_\_\_\_, hereby authorize MRI Center of Idaho or MRI Mobile and/or its staff to disclose my individually identifiable health information as described below. I understand that this authorization is voluntary. I understand that the information disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law.

**Patient Name:** \_\_\_\_\_

**Patient Date of Birth:** \_\_\_\_\_

**Information Released From (Facility):** \_\_\_\_\_

**Phone:** (\_\_\_\_\_) \_\_\_\_\_

**Fax:** (\_\_\_\_\_) \_\_\_\_\_

- |  |   |
|--|---|
| <input type="checkbox"/> Operative Report      | <input type="checkbox"/> Other (Specify)  |
| <input type="checkbox"/> Operative Room Record | <input type="checkbox"/> Radiology Report |
| <input type="checkbox"/> History and Physical  | <input type="checkbox"/> _____            |

Information Requested for the dates of: \_\_\_\_\_

Specific description of information to be disclosed: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

**Section B: Must be completed only if a health plan or a health care provider has requested the authorization**

1. The health plan or health care provider must complete the following:
  - a. What is the purpose of the use or disclosure: \_\_\_\_\_

(No purpose need be stated if the request is made by the patient and the patient does not wish to state the purpose.)

- b. Will the health plan or health care provider requesting the authorization receive financial or in-kind compensation in exchange for using or disclosing the health information described above? Yes\_\_\_ No\_\_\_
2. The patient or the patient's representative must read and initial the following statements:
  - a. I understand that my health care and the payment for my health care will not be affected if I do not sign this form. Initials: \_\_\_\_\_
  - b. I understand that I may see and copy the information described on this form if I ask for it, and that I will receive a copy of this form after I sign it. Initials: \_\_\_\_\_

**Section C: Must be completed for all authorizations**

**The patient or the patient's representative must read and initial the following statements.**

1. I understand that this authorization will expire on \_\_\_\_/\_\_\_\_/\_\_\_\_\_(DD/MM/YY) Initials: \_\_\_\_\_
2. I understand that I may revoke this authorization at any time by notifying MRI Center of Idaho/MRI Mobile in writing but if I do, it won't have any affect on any actions taken before receipt of my revocation.

MRI Center of Idaho/MRI Mobile will not condition my treatment of whether I provide authorization for the requested use or disclosure except (1) if my treatment is related to research, or (2) health care services are provided to me solely for the purpose of creating protected health information for disclosure to a third party. Initials: \_\_\_\_\_

The use or disclosure requested under this authorization will result in direct or indirect remuneration to my doctor from a third party. (If applicable because the authorization is obtained for marketing purposes.)

**Signature of patient or patient's representative:** \_\_\_\_\_ **Date:** \_\_\_\_\_

(Form MUST be completed before signing)

**Printed name of patient's representative (if applicable):** \_\_\_\_\_

**Relationship to patient (if applicable):** \_\_\_\_\_

**\* YOU MAY REFUSE TO SIGN THIS AUTHORIZATION \***