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 (Oregon)
****YOU MAY REFUSE TO SIGN THIS AUTHORIZATION****

Section A: Psychotherapy Notes. □ Check if this authorization is for psychotherapy notes.

If this authorization is for psychotherapy notes, it may not be used as an authorization for any other type of protected health information.

Section B: Your Information

Patient Name: ______________________________
Address: ______________________________
Date of Birth: ____________________ **Social Security Number:** ____________________
Phone: (__________) ______________ **Subscriber Number:** ____________________
Email: ______________________________

Section C: Terms and Conditions of Disclosure

No Conditions: This authorization is voluntary. We will not condition our payment activities in connections with your claims, your enrollment in our health plan or your eligibility for benefits on you giving this authorization.

Purpose of this Authorization: By signing this form, you authorize MRI Center of Idaho/MRI Mobile to disclose your protected health information for the following purposes: ______________________________
____
____

Designation of Records: By initialing the spaces below, I specifically authorize the release of following medical records, if such records exist:

- _ All hospital records (including nursing records and progress notes
- _ Transcribed hospital reports
- _ Operative reports/Operative room records
- _ Medical records needed for continuity of care
- _ Most recent five-year history
- _ Laboratory reports
- _ Pathology reports
- _ Diagnostic imaging reports
- _ Clinician office chart notes
- _ Dental records
- _ Other ______________________
- _ Physical therapy records
- _ Emergency and urgency care reports
- _ Billing statements
- _ Please send the entire medical record to the above-named recipient. (The recipient understands this record may be voluminous and agrees to pay all reasonable charges associated with providing this record.)
- _ *HIV/AIDS-related records
- _ *Mental health information
- _ *Drug/alcohol diagnosis, treatment or referral information

Effect of granting this authorization: The protected health information described below may be disclosed to and/or received by persons or organizations that are not subject to federal health information privacy laws. They may further disclose the protected health information, and it may no longer be protected by federal health information privacy laws.

Protected health information to be used and/or disclosed: The specific protected health information we are asking you to authorize to disclose for the purposes stated above is: ______________________________
____

This authorization is limited to the following treatment: ______________________________
____

This authorization is limited to the following time period: ______________________________
____

This authorization is limited to a workers' compensation claim for injuries of (date) ______________________

Inspection and copy of the protected health information: You have the right to inspect and/or copy the protected health information described above.

Persons/organizations receiving the information: The person and/or organization to whom you are authorization our Company to disclose and/or let use the protected health information described above are: ___________________________

____

Restrictions on use: Limitations, if any, on recipient's use of your protected health information: ____________________

____

Section D: Remuneration (Check One)

- ☐ Our company will *not* receive direct or indirect remuneration from a third party as a result of the disclosure of the protected health information requested by this authorization.
- ☐ Our company *will* receive direct or indirect remuneration from a third party as a result of the disclosure of the protected health information requested by this authorization.

Section E: Expiration and Revocation

Expiration: This authorization will expire (complete one)

- ☐ On ______/______/____________
- ☐ On occurrence of the following event (which must relate to the individual or the purpose of the disclosure being authorized): ____

____

____

Right to revoke: I understand that I may revoke this authorization at any time by giving written notice of my revocation to MRI Center of Idaho/MRI Mobile at the address listed below. I understand that revocation of this authorization will *not* affect any action you took in reliance on this authorization before you received my written notice of revocation. Unless revoked earlier, this consent will expire 180 days from the date of signing or shall remain in effect for the period reasonable needed to complete the request.

MRI Center of Idaho/MRI Mobile
Attn: Privacy Officer
949 N Curtis Rd.
Boise, ID 83706

SIGNATURE—YOU MAY REFUSE TO SIGN THIS AUTHORIZATION

I, ____, have had full opportunity to read and consider the contents of this authorization. I understand that, by signing this form, I am confirming my authorization that MRI Center of Idaho/MRI Mobile may disclose to the persons and/or organizations named in this form, the protected health information described in this form for the purposes stated in this form.

Signature ____ Date ___________________________________

If this authorization is signed by a personal representative on behalf of the individual, complete the following:

Legal Representative's Name: ____

Relationship to Individual: ____

*** YOU ARE ENTITLED TO A COPY OF THIS AUTHORIZATION AFTER YOU SIGN IT ***