HIPAA Friend and Family Form

Patient Name: _____ Date of Birth: _____

Authorization to Obtain Information

I give permission to Southlake MRI & Diagnostic Center to obtain previous diagnostic images on CD, radiology reports, surgical reports, implant information, and medical history as needed for continuation of care and Radiologist comparison.

I give permission to Southlake MRI & Diagnostic Center to obtain ALL necessary information to process my claim regardless of Date of Service should my insurance place my claim under review. This includes but is not limited to clinical notes, progress notes, office notes, lab results, other diagnostic imaging reports, History and Physical, surgical reports, and therapeutic services.

Release of Information

☐ Information is not to be released to anyone.

☐ I authorize release of information including the diagnosis, medical records, images, and billing records.

Please list below any person your information may be released to:

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Messages

The best number to reach me is: _____

☐ You may leave a detailed message.
☐ Please leave a message asking me to return your call.
☐ Do not leave a message.

This Release of Authorization will remain in effect until written revocation is provided to Southlake MRI & Diagnostic Center by the patient or legal representative.

Patient Signature: _____ Date: _____

A copy of our Notice of Privacy Practices is available upon request.