LONGHORN IMAGING

Longhorn Imaging Centers
Phone: (512) 444-8900 Fax: (512) 444-7244

Patient Name: _____ Date of Birth: _____

AUTHORIZATION FOR RELEASE OF PATIENT INFORMATION

I, the patient named above, or his/her parent/legal representative, hereby authorize the clinic named above to

☐ **Release To** ☐ **Obtain From**

Name of Clinic/Provider
Address:
City, State, Zip

Date Range
From: To:
Phone:
Fax:

The following individually identifiable health information for the purpose(s) listed below:

Information (check one or more)

☐ Complete medical record
☐ Immunization record
☐ Lab/Pathology reports
☐ Consultation reports
☐ Physical Therapy
☐ Discharge summary
☐ Alcohol/Substance abuse**
☐ Billing record
☐ Medication List
☐ Diagnostic reports
☐ Operative reports
☐ EMG/NCS
☐ Anesthesia record
☐ Other

For the purpose of (check at least one)

☐ Continuity Care by another Provider
☐ Disability
☐ Legal/Attorney
☐ Patient request
☐ Insurance
☐ School
☐ Other

NOTICE TO RECIPIENT: Federal rules prohibit further disclosure by the recipient of any alcohol or substance abuse records released under this Authorization unless the recipient has received written consent from the person to whom it pertains or as otherwise permitted by **42 CFR Part 2

Acknowledgements I understand that: 1. Individually identifiable health information may include information concerning communicable diseases such as Human Immunodeficiency Virus (HIV) and Acquired Immune Deficiency Syndrome (AIDS), mental illness (except psychotherapy notes), genetic testing, chemical or alcohol dependency, laboratory test results, medical history, treatment, or any other such related information. 2. I do not have to sign this Authorization and that my refusal to sign will not affect my ability to receive health care services or items. 3. The entity or person receiving information under this Authorization may not be subject to HIPAA or state privacy rules and the information released may no longer be protected by federal or state privacy rules. 4. I may cancel this Authorization at any time by submitting a written notice of revocation to the Clinic at the address listed at the top. The revocation will not affect any use or disclosure by the Clinic before receipt of the written revocation.

EXPIRATION: Authorization expires 180 days from the date signed or on the following date or event:

_____

Date: _____ Signature of Patient or Patient's Representative: _____

Printed Name: _____

Relationship to Patient: ☐ Self/patient, ☐ Parent, ☐ Legal Guardian, ☐ *Other: _____
**Attach legal document*

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FOR STAFF USE ONLY

Date request received: _____ Date request completed: _____ # of pages released: _____

Staff Name:_____ ☐ Paper Copies ☐ Electronic Copy

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TELEPHONE CONSUMER PROTECTION

You agree to receive pre-recorded/ artificial voice messages calls and/or use of an automatic dialing device, text messages and/or emails from Longhorn Imaging Center, our partners, subcontractors, or any and all other companies that we may have to transfer your account to, including collection agencies, at any telephone number or email address that you at any time provide us or that we have otherwise obtained, which could result in charges to you. We may place such calls, texts or emails to (i) notify you regarding upcoming appointments; (ii) notify you of results; (iii) troubleshoot problems with your account (iv) resolve a dispute; (v) collect a debt ; or (vI) as otherwise necessary to service your account or enforce this admissions agreement, our policies, applicable law, or any other agreement we may have with you.

The ways in which you may provide us a telephone number or email address include, but are not limited to, providing the information at account opening, adding the information to your account at a later time, providing it to one of our employees, providing it to our partners, subcontractors, or any and all other companies that we may have to transfer your account to, or by contacting us or our partners, subcontractors, or any and all other companies that we may have to transfer your account to from that phone number or email address. If a telephone number provided to us is a mobile telephone number, you consent to receive SMS or text messages at that number. Standard telephone minute and text charges may apply if we contact you. You may revoke this express consent at any time by calling us at: 512-444-8900.

Date: _____ Signature of Patient or Patient's Representative: _____

Printed Name: _____

Relationship to Patient: ☐ Self/patient, ☐ Parent, ☐ Legal Guardian, ☐ *Other: _____
**Attach legal document*