



**AUTHORIZATION FOR ATLANTIC MEDICAL IMAGING
TO OBTAIN RECORDS**



**Ramshorn Executive Centre
2399 Highway 34, Unit B, Manasquan, NJ 08736
Phone: 732-223-XRAY (9729) or 609-677-XRAY (9729)
Fax: 732-292-9950**

I hereby authorize _____
(Name of healthcare organization/provider)

to release the diagnostic imaging films and/or reports of:

_____/_____/_____
Patient Name (please print) Date of Birth

For date(s) of service from or between the dates of _____ / _____ / _____ to
_____ / _____ / _____.

Specific information/films/reports to be disclosed: _____

Information is to be released for the purpose of patient care.

It is to be released to Atlantic Medical Imaging at the address on this request, using the fax number indicated.

FAX: _____

I understand that the terms of this authorization are governed by the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and other applicable state and federal requirements.

I understand that I have the right to revoke this authorization at any time prior to the requested entity's compliance with the request. The revocation may be subject to the entity's Notice of Privacy Practices and other policies.

I understand that I am not required to sign this authorization and that Atlantic Medical Imaging may not condition treatment or services on my execution of this authorization.

I understand that information disclosed by this authorization may be re-disclosed by the recipient and will no longer be protected by HIPAA.

This authorization will expire upon the release of the information described above.

Signature of Patient or Personal Representative

Date

Personal representative's relationship to the patient: _____