



**HIGH RESOLUTION**  
OUR FOCUS IS YOUR HEALTH

**AUTHORIZATION TO USE AND/OR DISCLOSE MEDICAL RECORDS**

*I give authorization to the provider listed below to disclose a copy of the specific health/medical information identified below:*

NAME OF PATIENT	
DATE OF BIRTH	

<b>TO: RAA/Advanced Imaging, LLC</b>						
<b>Name</b>	RAA/Advanced Imaging LLC			<b>Phone</b>	505-332-5842/Fax: 505-332-5887	
<b>Address</b>	4411 The 25 Way NE, Suite 150					
<b>City/State Zip</b>	City	Albuquerque	State	New Mexico	Zip	87109

<b>RECORDS FROM: (Who is Releasing the Records)</b>						
<b>Name</b>				<b>Phone</b>		
<b>Address</b>						
<b>City/State Zip</b>	City		State		Zip	

**For the Following Purposes:**

<input type="checkbox"/>	Continued Medical Care	<input type="checkbox"/>	Personal Information	<input type="checkbox"/>	Legal Follow-up
<input type="checkbox"/>	Disability Insurance	<input type="checkbox"/>	Other:		

**By Checking the Boxes Below, I Specifically Authorize the Use and/or Disclosure of the Following Health Information And/or Medical Records, If Such Information And/or Records Exist:**

<input type="checkbox"/>	Please send the entire Medical Record (all information) to the above named recipient.				
<input type="checkbox"/>	Office Notes and Reports	<input type="checkbox"/>	Diagnostic Reports/Images	<input type="checkbox"/>	Billing Statements
<input type="checkbox"/>	Transcribed Hospital Reports				
<input type="checkbox"/>	Others Listed Here:				

<b>Date Range of Records Request</b>	From		To	
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**I understand** that, if the person or entity receiving the information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be re-disclosed and no longer protected by HIPAA and other federal and state regulations. However, the recipient may be prohibited from disclosing substance abuse information under the Federal Substance Abuse Confidentiality Requirements.

**I, further understand** that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment or payment of my eligibility for benefits. I may inspect or copy any information to be used and/or disclosed under this authorization.

**Finally, I understand** that **I may revoke this authorization**, in writing, at any time, provided that I do so in writing, except to the extent that action has been taken in reliance upon this authorization. Unless Revoked Earlier, this Authorization Will Expire in Six (6) Months from the Date of Signing or until (Insert Date): \_\_\_\_\_.

Print Patient's Name: \_\_\_\_\_ Date: \_\_\_\_\_

**Signature of Patient or Patient's Personal Representative:**

\_\_\_\_\_

Print Name of Personal Representative (if applicable): \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_

**A signed medical release is not required from the patient pursuant to HIPAA regulation standard 45 CFR 164.506 (c)(2) "A covered entity may without the individual's authorization disclose protected health information for the treatment activities of a healthcare provider."**