2601 Stafford Avenue
Scranton, PA 18505
P: 570 346-6633
F: 570 346-4049

Open High Field MRI
3T Ultra-High Field MRI
CT / CTA

Open PET/CT
Ultrasound
X-Ray

nepaimaging.com

Authorization To Release or Receive Medical Information

Patient Name: ______________________ **Date of Birth:** ______________**Imaging#**_________

I authorize an appropriate member of the above entity to release information from my medical record to:

____ **Northeastern Pennsylvania Imaging Center** 2601 Stafford Avenue, Scranton, PA 18505

Or from Northeastern Pennsylvania Imaging Center to:

______________________________ Phone ______________ Fax ________________

For the purpose of:

- continuation of medical treatment
- Education
- insurance purposes
- at the request of the patient/patient's legal representative for personal access or other (specify) ______________________________
- payment of bill/ Worker's Compensation
- legal purposes

I authorize the use of disclosure of my individually identifiable health information as described below. I understand this authorization is voluntary. I understand that if the organization authorized to receive the information is not a health plan or healthcare provider, the released information may no longer be protected by federal privacy regulations, and that it may be re-disclosed by the recipient.
I understand that I may revoke this Authorization at any time by notifying this specific entity listed above in writing, but if I do, it will not have any effect on any actions taken before they received revocation.

The information to be released will cover the time period from ____________ **to** ______________

Specific Information to be released

Modality	**Exam & Date**	**Exam & Date**	**Images**	**Reports**
MRI	____________	____________	______	______
CT	____________	____________	______	______
PET/CT	____________	____________	______	______
ULTRASOUND	____________	____________	______	______
BONE DENSITY	____________	____________	______	______
RADIOGRAPHS	____________	____________	______	______

I, ______________________________ (please print name), have had an opportunity to review and understand the contents of this form. By signing this form, I am confirming that it accurately reflects my wishes.

I understand this Authorization will expire in six (6) months from date of authorization.

____
Signature of Individual

_____ / _____ / _____
Month Day Year

08262015