CereScan®

AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

PLEASE FILL OUT EACH SECTION BELOW

PATIENT INFORMATION

Patient Name:

Date of Birth:

Medical Record Number:

Alias or Maiden Name:

Phone Number:

PLEASE CHECK THE INFORMATION TO BE RELEASED

- ☐ Report and Images
- ☐ Billing Information
- ☐ Appointment Information
- ☐ DICOM Data on CD
- ☐ Demographic information
- ☐ Information regarding neurological/psychological/psychiatric conditions
- ☐ Other:

TYPE OF REQUEST (CHECK ALL THAT APPLY):

☐ Printed Records ☐ Electronic Records ☐ CD*

**Please note, there is a $25 fee for delivery of CDs with records.*

HOW WOULD YOU LIKE THESE RECORDS TO BE DELIVERED? (CHECK ONE):

- ☐ Mail *address:*
- ☐ Fax *number:*
- ☐ Email *address:*

AUTHORIZATION

By my signature below, I authorize CereHealth Corp. to release my protected health information to the following individual(s):

Name: Relationship:

I understand that after the custodian of records discloses my medical or billing information, it may no longer be protected by federal and/or state privacy laws. I further understand that this authorization is voluntary and that I may refuse to sign this authorization. My refusal to sign will not affect my ability to obtain treatment, payment or eligibility for benefits, unless allowed by law. I understand this authorization maybe revoked in writing at any time, except to the extent that action has been taken in reliance on the authorization. Unless otherwise revoked, this authorization will expire 1 year from date of signature. You have the right to revoke this authorization, except to the extent the custodian of records has relied on it, by sending your written request to the Privacy Officer at: 991 Southpark Drive, Ste. 200, Littleton, CO 80120.

Patient or Authorized Representative Signature

Date of Signature

Printed Name of Patient or Authorized Representative

Relationship to Patient