DURANGO ULTRASOUND

AUTHORIZATION TO RELASE MEDICAL RECORDS

(DISCLOSURE OF PROTECTED HEALTH INFORMATION)

I understand that under the Health Insurance Portability Act (HIPPAA), I have certain rights to privacy regarding my protected health information (PHI). I acknowledge that I have received or have been given the opportunity to receive a copy of your Notice of Privacy Practices which provides a more complete description of such uses and disclosures. I also understand that this practice has the right to change its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained and forwarded with a written request to Durango Ultrasound, LLC at 270 E. 8th Ave., Ste 201, Durango, CO 81301.

Acknowledgement of privacy practices:

Name:_____date:_____

Patient Signature: _____

Medical release authorization:

I hereby give Durango Ultrasound permission to obtain the following information for the purpose of comparison of previous exams and exam correlation. I understand I have the right to revoke this authorization in writing to the above address.

Requested information:

Radiology report/images

Laboratory/Pathology results

Office notes

Durango Ultrasound Exam

Have you had a previous imaging study (CT, MRI or ultrasound) of the same area that we are scanning today? If yes, what type of study, what facility/provider and the date of exam.

Patient Name:_____ Date of birth:_____

Study type:_____Facility:_____

Name of provider:_____Date of exam:_____

Please fax above requested information to Durango Ultrasound at **970-247-7996**

To request a copy of ultrasound performed at Durango Ultrasound please fill out below:

Date of exam:_____Facility/provider to send exam to:_____

Address of facility or provider:_____

Phone/fax#:_____Email:_____

Your signature:_____date:_____