Advantage Imaging Solutions

Attention: Medical Records
220 Forbes Road, Suite 304
Braintree, MA 02184
Phone: (781) 848-0085 Fax: (781) 987-7220

Authorization for Use and Disclosure of Patient Health Information

Name of Patient _____ Maiden or Previous Name _____ Date of Birth _____

Street Address _____ City, State, Zip Code _____

Phone Number: (Home) _____ (Cell) _____ (Work) _____

AUTHORIZE: Advantage Imaging Solutions		**RELEASE RECORDS TO:**	
Name of Healthcare Facility		Name of Physician/Healthcare Facility/or Person	
Street Address		Street Address	
City, State, Zip Code		City, State, Zip Code	
Telephone #	Fax #	Telephone #	Fax #

RECORDS TO BE RELEASED:

☐ Ultrasound Report (Specify Date(s):_____)

☐ Ultrasound Images (Specify Date(s):_____)

☐ Other:_____

Reason for Disclosure:	**I would like this information released for the following purpose:**
	☐ Continued care by another provider ☐ Insurance purposes
	☐ Attorney ☐ Other_____

I have read and understood the following:

- If I change my mind, I may write to the facility that I have authorized to release my records. This will not apply to records that have already been released.
- There may be a fee for releasing these records.
- Once the records are released, AIS cannot prevent them from being released to a third party.
- To be valid, this form must be filled out completely and signed. A copy is valid if it has not been altered.

_____ _____ _____

Signature of patient or authorized person (If authorized person is signing, please also print name)

Authorized person's authority to sign (parent, guardian, power of attorney, etc.)

Date

***photo ID required to pick up records/films**

REASON PATIENT IS UNABLE TO SIGN: ☐ Minor ☐ Deceased ☐ Other: _____