Attention: Medical Records
300 Congress Street, Suite 103
Quincy, MA 02169
Phone: (781) 848-0085 Fax: (781) 987-7220
info@advantage-imaging.com

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:	**RELEASE RECORDS TO:**
_____ Name of Physician/Healthcare Facility/or Person	_____ 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: _____