Release of Information Form

When completed, this form will allow Bluegrass Regional Imaging to release protected health information to the party or parties listed below. This form applies to any and all services performed at Bluegrass Regional Imaging until future notice. I understand that I have the right and responsibility to revoke this authorization by completing a new form.

I, ______________________________ the undersigned, do hereby authorize Bluegrass Regional Imaging to release my personal health information to

________________________________(name),______________(relationship),

________________________________(name),______________(relationship),

________________________________(name),______________(relationship),

________________________________(name),______________(relationship),

________________________________(name),______________(relationship),

This authorization includes, but is not restricted to, a right to review and obtain copies of all medical records including: written reports of PET and CT scans, and other such test results; doctor's notes; medical charts; diagnoses; opinions; prescriptions; billing and courses of treatment.

____
Signature of Patient

____
Date of Birth

____
Witness

Billing Department
1218 South Broadway, Suite 310 Lexington, Kentucky 40504-2759 859-219-0542 Fax 859-219-9433