SIKER | MEDICAL
IMAGING AND INTERVENTION

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RCVKGPV'AUTHORIZATION TO'DISCLOSE HEALTH INFORMATION'VQ'UKMGT'MEDICAL IMAGING

PATIENT NAME: ______________________________________ DOB______________________

PRIOR RECORDS UNDER DIFFERENT LAST NAME: _______________________________

FOR CONTINUING CARE, I AUTHORIZE:

Doctor or Facility Name: _____________________________________ Phone: ______________

Address: ____ Email: ____________________

TO DISCLOSE/USE MY HEALTH INFORMATION CONSISTING OF:

Study type/area of body, and date of service, if you have it:

____

□ **Reports** □ **Chart Notes**

□ **Reports/DICOM CD of Study** □ **Other** _______________________________________

TO: Siker Medical Imaging
1800 NE 2nd Ave
Portland OR 97212
PH: 503-595-3967
FAX: 503-595-3937

BY PATIENT OR LEGAL REPRESENTATIVE:

(signature)____ Date: ___________

(print name)____

RELATIONSHIP OF LEGAL REPRESENTATIVE:_________________________________

YOU HAVE THE RIGHT TO REVOKE THIS AUTHORIZATION AT ANY TIME. THE REQUEST MUST BE DONE IN WRITING TO THE ABOVE ADDRESS. IF YOU REVOKE YOUR AUTHORIZATION, WE WILL NO LONGER USE OR DISCLOSE INFORMATION ABOUT YOU FOR THE REASONS COVERED BY THIS AGREEMENT. WE CANNOT, HOWEVER, TAKE BACK ANY USES OR DISCLOSURES ALREADY MADE WITH YOUR PERMISSION.