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AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

PATIENT NAME: ______________________________**Date of Birth:** ______________________

Contact phone number in case I have questions: ____

I AUTHORIZE: Siker Medical Imaging, 1800 NE 2ND Ave, Portland OR 97212
Fax: 503-595-3937
E-Mail: info@SikerMedical.com

TO DISCLOSE MY HEALTH INFORMATION CONSISTING OF (Date of service, Type of study **AND** Do you want just Report emailed, mailed or faxed; CD/Report mailed; Report/Link to study emailed):

____

TO: □ **SELF** □ **OTHER (provide name)**____

□ **MAIL TO ADDRESS:** ____#_________

____

□ **FAX #** ____

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IF EMAILING RECORDS, CASE-SENSITIVE PASSWORD – six or more characters:

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↑ Please indicate capitalized letter by underlining

I HAVE REVIEWED AND UNDERSTAND THIS AUTHORIZATION. I UNDERSTAND THAT THE INFORMATION USED OR DISCLOSED PURUSANT TO THIS AUTHORIZATION MAY BE SUBJECT TO REDISCLOSURE BY THE RECIPIENT AND NO LONGER PROTECTED UNDER FEDERAL LAW.

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(print name)____
PATIENT OR PATIENT REPRESENTATIVE

RELATIONSHIP OF PATIENT REPRESENTATIVE:_________________________________

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