

## Patient Record of Disclosures

In general, the HIPAA rule gives individuals the right to request restrictions on the use and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communication of PHI be made by alternative means. Please note below your preferences.

I wish to be contacted in the following manner (check and complete all that apply)

\_\_\_\_\_ Home Phone #: \_\_\_\_\_

\_\_\_\_\_ OK to leave message and information

\_\_\_\_\_ Leave message with call back # ONLY

\_\_\_\_\_ Work Phone #: \_\_\_\_\_

\_\_\_\_\_ OK to leave message and information

\_\_\_\_\_ Leave message with call back # ONLY

\_\_\_\_\_ Cell Phone #: \_\_\_\_\_

\_\_\_\_\_ OK to leave message and information

\_\_\_\_\_ Leave message with call back # ONLY

\_\_\_\_\_ Other Phone #: \_\_\_\_\_

\_\_\_\_\_ OK to leave message and information

\_\_\_\_\_ Leave message with call back # ONLY

Listed below are the names of the persons you authorize Greater Flint MRI to release information to (other than your primary/referring physician and insurance provider):

Name: \_\_\_\_\_

Relationship: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Phone #: \_\_\_\_\_

\_\_\_\_\_ They may have access to all information from this office

\_\_\_\_\_ Billing information only

Name: \_\_\_\_\_

Relationship: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Phone #: \_\_\_\_\_

\_\_\_\_\_ They may have access to all information from this office

\_\_\_\_\_ Billing information only

Films and/or digital media will be released to your primary care physician (if noted), and referring physician (if not your primary) after the Radiologist has reported your scan. If in the future, more films/digital media or Radiology reports are needed for further care, you will need to complete a medical release form, for the new physician or institution, in order for Greater Flint MRI to release your records. Please acknowledge and approve this release with your initials: \_\_\_\_\_ Date: \_\_\_\_\_

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed Name

\_\_\_\_\_  
Date of Birth

\_\_\_\_\_  
Witnessed By

