Medical Records Release

Patient Name: REDACTED
Phone: REDACTED
Address: REDACTED
City: REDACTED REDACTED Zip: REDACTED

When billing insurance for CT procedure(s), your insurance provider may request your medical history and physical. HIPPA compliance requires that you sign this consent to release information to our facility so that we may forward the information to your insurance company upon request.

We are always working to improve our results and make this test as accurate as possible. Currently we are approximately 92% accurate compared to angiography, but would like to improve these figures. To do this, we need your help. We would like your permission to contact your physician for medical records if necessary. Specifically, we would like to compare our results to any angiograms (old or upcoming), and stress tests. We will keep your records in the utmost confidence, and will never publish any data with any type of identifier. This constant analysis will enable us to continue to improve the test, making it a true replacement for angiograpghy in the future. If you are willing to let us use your information, please fill sign below. This will give us permission to get limited records from your doctor.

Your health information may be provided to a researcher for research purposes. In some situations, we may disclose your information to researchers preparing a research protocol or if our Institutional Review Board (IRB) Committee determines that an authorization is not necessary. The IRB Committee is charged with ensuring the protection of human subjects in research. We also may provide limited health information about you (not including your name, address, or other direct identifiers) for research, public health or health care operations, but only if the person or organization that receives the information signs an agreement to protect the information and not use it to identify you.

I authorize the release of (if applicable): Hospital Discharge Summary, Angiography Reports, History and Physical Exam, Operative report, Pathology Reports, Stress Testing (including nuclear and echocardiography) and other information as necessary. Note: A copy of this authorization is valid as the original, and is valid as for the length of the study.

I authorize my physician to release any information such information as medical/physical history to :

Diagnostic And Wellness Center/ Prohealth Partners, A Medical Group Inc.
1124 W. Carson Street, Torrance, CA 90502
Tel: (310) 222-2773 - Fax: (310)320-5573

We may change this Notice when the law or our practices change. We reserve the right to make the revised or changed Notice effective for health information we already have about you as well as any information we receive in the future. You will not automatically receive a new Notice. If we change this Notice, we will post the revised Notice in our facilities and on the above-mentioned websites. You may also obtain any revised Notice from the facility where you obtain health care.

REDACTED