SUN VIEW
IMAGING SERVICES

# Attestation/Confirmation of CD and/or Records

*Released to the Patient / Patient Guardian*

| Name: | Date of Birth: |
|---|---|
| Address: | Phone: |

**Specify Information Type to be disclosed**:
The information that is to be released under this Attestation includes the following: (please initial next to type applying)

_____**CD** _____ **CD and Reports** _____ **Reports Only**

**Please select option:** _____ **Mail** _____ **Pick Up**

Date of Service: _____ Exam Description: _____

Date of Service: _____ Exam Description: _____

Date of Service: _____ Exam Description: _____

**Name of Recipient or class of persons to whom Sun View Imaging Services is releasing items to**:
_____

**TERM: This authorization will remain in effect:**
___From date of this Authorization until _____day of _____, 20____.
___Other: _____
I authorize Sun View Imaging Services to release the above items indicated to me, the patient / guardian and I confirm and attest that I will be responsible for providing said records to my referring physician.

Signature: _____

**I understand that once Sun View Imaging Services discloses my health information to the recipient, Sun View Imaging Services cannot guarantee that the recipient will not redisclose my health information to a third party. The third party may not be required to abide by this Authorization or applicable federal and New Mexico law governing the use and disclosure of my health information.**
**I understand that Sun View Imaging Services may, directly or indirectly, receive remuneration from a third party in connection with the use or disclosure of my health information.**
**I understand that I may refuse to sign or may revoke (at any time) this Authorization for any reason and that such refusal or revocation will not affect the commencement, continuation or quality of my treatment at Sun View Imaging Services; except, however if my treatment at Sun View Imaging Services is for the sole purpose of creating health information for disclosure to the recipient identified in the Authorization, in which case Sun View Imaging Services may refuse to release my records to me if I do not sign this Authorization.**

I understand that this Authorization will remain in effect until the term of this Authorization expires or I provide a written notice of revocation to Sun View Imaging Services Privacy Officer at the address listed below. The revocation will be effective immediately upon Sun View Imaging Services receipt of my written notice, except that the revocation will not have any effect on any action taken by Sun View Imaging Services in reliance on this Authorization before it received my written notice of revocation.

I may contact Sun View Imaging Services Privacy Officer Temujin Martinez, by Fax at 575-521-7982, by telephone 575-522-6236 or by email at Temujin.Martinez@tenethealth.com

**I have read and understand the terms of this Authorization and I have had an opportunity to ask questions about the use and disclosure of my health information. By my signature, I hereby, knowingly and voluntarily authorize Sun View Imaging Services to use or disclose my health information in the manner described above.**

_____ _____
Signature of Patient Date

**NOTE:** If patient is a minor or otherwise unable to sign this Authorization, obtain the following signatures:

_____ _____ _____
Signature of Authorized Representative Relationship to Patient Date