PREMIER DIAGNOSTIC IMAGING

AUTHORIZATION FOR RELEASE OF CONFIDENTIAL HEALTH INFORMATION

Patient's Name____

Date of Birth__________________________________ **Medical Record #**______________________

Person/Organization authorized to RELEASE the information:

____

Person/Organization Authorized to RECEIVE the information:

____

(Note: If information is to be picked up by someone other than the person authorized to sign, this person must be named above and positive identification is required at the time of pick-up.)

Address (if information is to be mailed) ____

____

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Fax (if information is to be faxed) (_)____

(Note: Due to risks associated with faxing confidential information, Premier Diagnostic Imaging limits faxing to special circumstances such as patient care and the sharing if information with physicians and other health care professionals. If you authorize Premier diagnostic Imaging to fax the information please write the fax number above.)

Specific information to be released including dates____

Purpose of disclosure: ____

(Note: If information is at the request of a "covered entity" for marketing purposes, the provider must state if they □will or □ will not receive direct or indirect compensation for the use of this information.)

This information will expire on ____/___/______ (dd/mm/yr) or with the following event: ______________________

(Note: If not indicated above, this authorization will expire one year from the date of signature below)

I authorize Premier Diagnostic Imaging (PDI to release my confidential health information as described above. I understand that I have a right to inspect or obtain a copy of my health information as permitted under state or federal law. I understand that the specific information to be disclosed may include testing or treatment for drug/alcohol abuse, mental health, Human Immunodeficiency virus (HIV) and/or Acquired immune Deficiency Syndrome (AIDS), if applicable.

I understand that information disclosed has the potential for re-disclosure by the recipient and may no longer be protected by federal privacy regulations.

I understand I have the right to revoke this authorization, in writing, at any time by sending such written notice to the Privacy Officer at PDI. I understand that revoking this authorization stops any further disclosures but cannot undo any disclosures that have already occurred as requested in the original authorization.

I may refuse to sign this authorization. PDI may not condition my treatment, payment, enrollment in a health plan or legibility for benefits on whether I provide authorization for this requested use or disclosure, unless it is required in order to participate in research-related treatment.

I understand PDI may charge a reasonable fee for the supplies, labor and postage involved in copying and mailing this information unless otherwise limited by law. PDI will either notify you or send an invoice when there is an associated fee.

______________________________ ______________________

Patient Signature (or Personal Representative) **Date**

(Note: If the patient is represented by another person, please include a description of your legal authority to act for the individual and (if applicable) attach a copy of the proof of legal representation.)______________________________

***FOR PDI USE ONLY**

Records received by______________________________ ______________________

Signature of Person Receiving Records **Date**

Records Mailed________ **Records Faxed**_________ **Date**_________________ **(initials)**