Form # 4

Community Radiology

AUTHORIZATION TO USE AND DISCLOSE HEALTH INFORMATION

Patient Name: _____
Last First Middle

Home Address: _____
_____

Home Telephone: _____ **Date of Birth:** _____

SPECIFY INFORMATION TO BE DISCLOSED: _____
_____
_____
_____
_____

Note: If your health information contains any genetic, HIV/AIDS related (i.e., information regarding any HIV related test, infection, illness including AIDS), venereal disease and/or tuberculosis information, you must specifically mention "genetic information," "HIV/AIDS related information," "venereal disease information," and/or "tuberculosis information" if you want the Practice to disclose such information to any person other than you or your personal representative.

RECIPIENT: Name of person or class of persons to whom the Practice may disclose my health information: _____
Address of the recipient or where my health information should be delivered: _____
_____

TERM: This Authorization will remain in effect:
☐ From the date of this Authorization until the _____ day of _____, 200__.
☐ Until the following event occurs: _____
☐ Other: _____

By my signature below, I hereby authorize the Practice to use or disclose to the recipient my health information for the term of this Authorization for the following specific purpose(s): ("At the request of the patient" is sufficient if the patient is initiating this Authorization): _____
_____
_____

I understand that once the Practice discloses my health information to the recipient, the Practice cannot guarantee that the recipient will not redisclose my health information to a third party. Any such third party may not be required to abide by this Authorization or applicable federal and state law governing the use and disclosure of my health information.

I understand that the Practice will, 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 the Practice's

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