treatment of me; except, however, if my treatment at the Practice is for the sole purpose of creating health information for disclosure to the recipient identified in this Authorization, in which case the Practice may refuse to treat 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 the Practice's Privacy Office at the address listed below. The revocation will be effective immediately upon the Practice's receipt of my written notice, except that the revocation will not have any effect on any action taken by the Practice in reliance on this Authorization before it received my written notice of revocation.

I may contact the Practice's Office Manager by mail at 434 New Jersey Ave, Absecon, NJ 08201, or I may contact the Office Manager by telephone at 609-383-0500.

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 below, I hereby, knowingly and voluntarily, authorize the Practice to use or disclose my health information in the manner described above.

Signature of Patient	Date

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

Signature of Personal Representative	Description of Authority	Date

[If Community Radiology has requested this Authorization, provide a copy of the signed Authorization to the patient.]