DALTON IMAGING CENTER

AUTHORIZATION FOR USE/RELEASE OF HEALTH INFORMATION

(This form applies only to the release and disclosure of information. It is not a consent for treatment or intended for any other purposes.)

By signing this form, I authorize Dalton Imaging Center to use, release or disclose the protected health information described below to:

Name of person and/or organization to whom information should be sent:

_____

Address of person/organization to whom information should be sent:

_____

Please send this information on or about (information will not be resent without another authorization): ___/___/__
Mo Day Year

This authorization expires upon fulfillment of request unless special circumstances noted below**
Purpose of disclosure (at request of patient, employment, life or disability insurance, etc.):

I authorize the following information to be sent to the address above:

Copies of all medical records for the period ____/___/___ to ___/___/____
Mo Day Year Mo Day Year

Copies of the information described below

for period ____/___/___ to ___/___/____
Mo Day Year Mo Day Year

_____ History and Physical Examination _____ Lab, X-ray, etc. Reports

_____ Reports from Other Physicians _____ Other (Please Specify)

I understand that this information may include any history of acquired immunodeficiency syndrome (AIDS), sexually transmitted diseases, human immunodeficiency virus (HIV) infection, behavioral health services/psychiatric care, treatment for alcohol and/or drug abuse, or similar conditions.

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The following information should not be released, even if occurring during dates above:

** Please describe any special requirement such as faxing, certified mail, extended expiration date, and the like:

I understand that there may be information in these records that I would not want released.

I have been provided a copy of Dalton Imaging Center's Notice of Privacy Practices and any charges that may be associated with this authorization. I have discussed any concerns I may have about the use, release, disclosure of my health information with Dalton Imaging Center's Privacy Officer or other appropriate office personnel.

I understand that Dalton Imaging Center assumes no responsibility for the use or misuse by others of my health information disclosed under this authorization. I release Dalton Imaging Center from all legal liability that may arise from this authorization.

Patient's Signature: _____ Date: _____

SSN#: _____ DOB: _____ / _____ / _____
Mo Day Year

If the signature above is not that of the patient, I am acting for the patient because:

_____

My relationship to the patient is: _____

Signed: _____

The patient or their representative may revoke this authorization by notifying in writing Dalton Imaging Center's designated Privacy Officer. Federal law states that treatment, payment, enrollment or eligibility for benefits may not be conditioned on obtaining this authorization if such conditioning is prohibited by the Privacy Rule. Federal Law also requires a statement that there is the potential for the protected health information released under this authorization may be subject to redisclosure by the recipient.