

AUTHORIZATION FOR RELEASE OF INFORMATION TO FAMILY AND/OR FRIENDS

Name of Patient: _____ DOB: ____ / ____ / ____
Mo Day Year

Dalton Imaging Center is authorized to release protected health information about the above named patient to the entities named below.

Entity to Receive Information. Initial each that is subject to this authorization.

- _____ Leave information on the voice mail
- _____ Give information to spouse
- _____ Give information to the following persons:

Description of information to be release

- _____ Financial Information
- _____ Information results from tests or X-rays
- _____ Family Billing Information
- _____ Medical information as follows: _____

Other information as described: _____

TIME LIMIT:

RIGHTS OF THE PATIENT

I understand that I have the right to revoke this authorization at any time and that I have the right to inspect or copy the protected health information to be disclosed as described in this document by sending a written notification to _____ .

I understand that a written revocation is not effective in cases where the information has already been disclosed but will be effective going forward.

I understand that information used or disclosed as a result of this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law.

I understand that I have the right to refuse to sign this authorization and that my treatment will not be conditioned on signing this authorization.

This authorization shall be in force and effect until revoked by the patient or representative signing the authorization.

Signature of Patient or Personal Representative Date

Description of Personal Representative's Authority (attach necessary documentation)