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Radiology Associates L.L.C.

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

Patient Identification

Printed Name: _____("Patient") **DOB: _____** **SSN: _____**

Telephone: _____

Authority to Release Protected Health Information

I hereby authorize any **RADIOLOGY ASSOCIATES, L.L.C.** ("Provider") to release the information identified in this authorization from the medical records of Provider and provide such information to the following individual(s):

_____

_____

_____

The following information is to be released: Patient's entire medical records file, including but not limited to: office notes, correspondence, existing narrative reports, x-ray films and reports, CT Scan films and reports, diagnostic films and reports, etc., hospital records, lab results, HIV test results, patient intake forms, initial application and information sheets, consultation reports, physical therapist reports, progress notes, handwritten notes, nurses' notes, records of prescriptions, patient orders, pathology slides, and any and ALL other medical records compiled by you or in your possession pertinent to the treatment of me.

This release authorizes the release of tangible medical information and verbal communications with the above-listed individual(s).

Purpose of the Requested Disclosure of Protected Health Information

I am authorizing the release of my protected health information for the following purposes: at the request of the Patient.

Drug and/or Alcohol Abuse, and/or Psychiatric, and/or HIV/AIDS Records Release

I understand if Patient's medical or billing record contains information in reference to drug and/or alcohol abuse, psychiatric care, sexually transmitted disease, hepatitis B or C testing, and/or other sensitive information, I agree to its release. I further understand if Patient's medical or billing record contains information in reference to HIV/AIDS (Human Immunodeficiency Virus/Acquired Immunodeficiency Syndrome) testing and/or treatment, I agree to its release.

Right to Revoke Authorization

Except to the extent that action has already been taken in reliance on this authorization, the authorization may be revoked at any time by submitting a written notice to Provider. Unless revoked, this authorization will expire upon Patient's death.

Re-disclosure

I understand the information disclosed by this authorization may be subject to re-disclosure by the recipient and no longer be protected by the Health Insurance Portability and Accountability Act of 1996.

Signature of Patient or Personal Representative Who May Request Disclosure

I understand that I do not have to sign this authorization, and Patient's treatment or payment for services will not be denied if I do not sign this form. I can inspect or copy the protected health information to be used or disclosed.

A photostatic copy of this Authorization shall be considered as effective and valid as the original.

Signature: _____ Date: _____

Description of relationship if not Patient: _____

(If this authorization is being signed by someone other than the patient, documentation such as a health care power of attorney may be required to confirm such individual's authority to execute this authorization.)

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