

Patient Authorization to Use or Disclose Protected Health Information

I. Patient Name: _____ **Date of Birth/SSN:** _____

I understand by signing below I am authorizing Steinberg Diagnostic Medical Imaging (SDMI) to disclose my protected health information as described to the recipients listed below.

II. I authorize the persons below to receive my protected health information:

Name of Person/Facility: _____

III. Purpose of the release of PHI:

IV. Information to be used or disclosed (*check all that apply*):

- | | |
|---|--|
| <input type="checkbox"/> Complete Medical Record | <input type="checkbox"/> Billing Statement _____ |
| <input type="checkbox"/> Specific Condition _____ | <input type="checkbox"/> Specific Date of Service: _____ |
| <input type="checkbox"/> Other (specify): _____ | |

I understand and agree that the information that I am authorizing may include

- AIDS/HIV Results Genetics Testing Drug Screen Results & Information Mental Health Information

V. I understand and agree that this authorization is voluntary and I may refuse to sign this Authorization. I further understand that my treatment will not be affected if I do not sign this form. I understand that when the information is used or disclosed, pursuant to this authorization, it may be subject to re-disclosure by the recipient and may no longer be protected by the Federal HIPAA privacy rule.

I further understand that I may revoke this Authorization at any time by notifying SDMI in writing, ALL revocations are not effective until received by the Compliance Office except to the extent that action has been taken in reliance on it. Unless earlier revoked this authorization shall expire on _____ or after third party claims have been paid or satisfactorily resolved, whichever occurs last. After this date, Steinberg Diagnostic Medical Imaging Centers can no longer use or disclose the protected health information without first obtaining a new authorization form.

I release SDMI and its agents, representatives, employees from any and all liability associated with the release of confidential patient information in accord with this Authorization. I understand SDMI cannot be responsible for use or re-disclosure of information to third parties. (45 C.F.R. 164.508(c)(2)).

To the receiving party: This information has been disclosed to you for the sole purpose stated in this Authorization. Any other use of this information without the express written consent of the patient is prohibited. These records may be protected by federal regulation.

I fully understand and accept the terms of this authorization.

Print Name and Relation to Patient

Date

Patient/Other Legally Authorized Person Signature

**Instructions for completing
Patient Authorization to Use or Disclose Protected Health Information**

1. Print legibly in all fields using dark permanent ink.
2. Section I, print your name or the name of the patient whose information is to be released.
3. Section II, print person or facility that will receive your information.
4. Section III, the reason why the information is needed.
5. Section IV, check the appropriate box as applicable.
 - a. Entire Record - complete record including, if authorized, the sensitive information (alcohol and drug abuse treatment/referral, HIV/AIDS-related treatment, and mental health other than psychotherapy notes).
 - b. Billing Statement - Billing information, Statements, and invoices.
 - c. Only information related to specific condition or diagnosis.
 - d. Specific Date of Service - specify date or date range
 - e. Other - specify injury, claim, continuing medical care, etc.
6. Section V, expiration date or expiration of event.
7. Section V, please sign and date.