UPSTATE CAROLINA RADIOLOGY

AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION

Patient's Name: _____ DOB: _____ Last four of SSN: _____
Patient's Street Address: _____ Apt/Unit #: _____
City: _____ State: _____ Zip: _____

1. AUTHORIZED PERSONS TO USE AND DISCLOSE PROTECTED HEALTH INFORMATION:

_____is authorized to disclose the following protected health information to:
("Covered Entity")

Name: _____
Street Address: _____
City, State, Zip: _____
Phone: _____

2. DESCRIPTION OF INFORMATION TO BE DISCLOSED. The health information that may be disclosed is (*choose one*):

	Any and all imaging, billing, and administrative records (EXCLUDING discs of imaging studies)	Specify dates:
	Imaging study reports ONLY	Specify dates:
	Administrative records ONLY	Specify dates:
	Billing records ONLY	Specify dates:
	CD(s) of imaging studies	Specify dates:

3. PURPOSE OF THE USE OR DISCLOSURE: The purpose of this use or disclose is (*circle one*):

CONTINUED MEDICAL CARE	PERSONAL INTEREST	LEGAL PURPOSE	INSURANCE CLAIM	OTHER (SPECIFY):

4. VALIDITY OF AUTHORIZATION

This authorization is valid beginning as of the undersigned date and expires _____. (specify date or event)

5. ACKNOWLEDGMENT

I understand: 1) I have the right to refuse to sign this authorization and _____ *(covered entity)* may not change or deny treatment on the condition that I sign this form. However, if unsigned, _____ *(covered entity)* may not be able to use or disclose the PHI as requested. 2) If signed, I have the right to revoke this authorization, in writing, at any time. If revoked, any action already taken in reliance on this authorization cannot be reversed, and the revocation will not affect those actions. 3) THE INFORMATION USED OR DISCLOSED UNDER THIS AUTHORIZATION MAY BE SUBJECT TO FURTHER DISCLOSURE BY THE PERSON(S) OR FACILITY RECEIVING IT AND COULD THEN NO LONGER BE PROTECTED BY FEDERAL PRIVACY REGULATIONS. _____ *(covered entity)* IS NOT RESPONSIBLE FOR FURTHER DISCLOSURES BY A RECEIVING PARTY.

By: _____ Date: _____
(Patient Signature)

If personal representative requesting:

By: _____ Date: _____
(Personal Representative Signature)

Print Name of Personal Representative: _____ Relationship to Patient: _____