Comprehensive Radiology Services, PLLC
Authorization for Use and Disclosure of Protected Health Information

Patient Identification

Printed Name: ______________________________ Date of Birth______________

Address: ____

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Social Security #: ______________________________ Telephone: ______________

Information To Be Released – Covering the Periods of Health Care:

From (date) ______________________ to (date) ______________________

From (date) ______________________ to (date) ______________________

Please check type of information to be released:

☐ Entire medical charge history
☐ Itemized bill

☐ Other, (specify) ____

Purpose of Request

☐ Treatment consultation	☐ At the request of the patient	☐ Billing or claims payment

☐ Other (specify) ____

Person Authorized to Receive Information

Name: ____

Address: ____

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Time Limit & Right to Revoke Authorization

Except to the extent that action has already been taken in reliance on this authorization, at any time I can revoke this authorization by submitting a notice in writing to the facility Privacy Officer at *Comprehensive Radiology Services, P.L.L.C., 5000 West 4th Street, Hattiesburg, MS 39402*. Unless revoked, this authorization will expire on the following date or event ______________________________.

Re-disclosure

I understand the information disclosed by this authorization may be subject to re-disclosure by the recipient and will no longer by protected by the Health Insurance Portability and Accountability Act of 1996. The facility, its employees, officers and physicians are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein.

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Signature of Patient or Personal Representative Who May Request Disclosure

I understand that *Comprehensive Radiology Services, P.L.L.C.* may not condition my treatment on whether I sign this authorization form unless specified above under Purpose of Request. I can inspect or copy the protected health information to be used or disclosed. **I authorize Comprehensive Radiology Services to use and disclose the protected health information specified above.**

Signature: ____ Date: ____________________

Authority to Sign if not patient: ____

State of ___________________________ ____________________________________
Signature

County of __________________________

Sworn to and subscribed before me:

________________________________ My Commission Expires: ____________________
Notary Public