

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

Patient Identification

Printed Name: _____ Date of Birth _____

Address: _____

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:

<input type="checkbox"/> Entire medical charge history
<input type="checkbox"/> Itemized bill

Other, (specify) _____

Purpose of Request

<input type="checkbox"/> Treatment consultation	<input type="checkbox"/> At the request of the patient	<input type="checkbox"/> Billing or claims payment
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Other (specify) _____

Person Authorized to Receive Information

Name: _____

Address: _____

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 be 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:

Notary Public

My Commission Expires: _____