AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

I authorize _____ ("Provider") to disclose protected health information ("PHI") regarding:

Patient Name: _____ Patient Date of Birth: _____

Patient Address: _____

_____

I authorize the PHI be disclosed at my individual request to the following recipient:

Name: **GATEWAY RADIOLOGY CONSULTANTS, PA** Physical address: 4800 Park Blvd., Pinellas Park FL, 33781

Telephone number(s): 727-525-2121 Fax number: 727-526-5872 ATTN: MEDICAL RECORDS

Check one:

I authorize the following PHI to be released:

___ All health information about the patient in the possession of Provider, including, but not limited to psychiatric, mental health treatment information excluding psychotherapy notes, HIV test results, genetic testing information or alcohol or drug treatment information;

___ For a limited time period beginning _____ and ending _____ all health information about the patient in the possession of Provider, including, but not limited to psychiatric, mental health treatment information excluding psychotherapy notes, HIV test results, genetic testing information or alcohol or drug treatment information;

___ Limited PHI about the patient in the possession of Provider to exclude the following information which I request not be disclosed: _____

_____.[i]

___ Other, as described here_____.

I understand and acknowledge the following statements:

1. I may revoke this authorization at any time by notifying the Provider in writing of the revocation, unless the Provider has already relied on this authorization to disclose PHI;
2. PHI disclosed may be subject to re-disclosure and no longer be protected by federal or state privacy laws;
3. I am signing this authorization voluntarily. I may decline to sign this authorization. However, refusal to sign does not stop the Provider's disclosure of PHI that is otherwise permitted to be disclosed by law without my specific authorization;
4. Provider will not condition my treatment on whether I sign, or refuse to sign, this authorization;
5. I will receive a signed copy of this form.
6. I understand that unless otherwise revoked, this authorization will expire one year after the patient is discharged from Provider's care.

Check one:

____ I am the patient and I understand and agree to the provisions of this authorization.

____ I understand and agree to the provisions of this authorization on behalf of the patient named above. I have signed my name individually as the parent of a minor patient OR as the representative of the adult patient and have attached, or previously provided, a copy of the document authorizing me to serve as the patient's legal representative.

_____ _____

Signature of Patient or Legal Representative Date

_____ _____

Signature of Parent/Legal Representative/Competent Adult (if applicable) Date

_____ _____

Signature of Witness Date

[i] The Provider is authorized by law to use or disclose PHI for a variety of reasons without the patient's authorization. Please see the Provider's Notice of Privacy Practices for details.

This authorization was developed to comply with the Health Insurance Portability and Accountability Act of 1996, the Health Information Technology for Economic and Clinical Health Act, the American Recovery and Reinvestment Act of 1009 and associated regulations.