**AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION**

**Section A: Must be completed for all authorizations**

I hereby authorize the use and disclosure of my individually identifiable health information as described below. I understand that this authorization is voluntary. I understand that if the organization authorized to receive the information is not a health plan or health provider; the released information may no longer be protected by federal regulations.

**Patient name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ID/Acct Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

 **SS# \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Persons/organizations providing the information: Greensboro Radiology**

 **1331 N Elm Street, Suite 200**

 **Greensboro, NC 27401**

 **Phone: 336-273-7051**

 **Fax: 336-274-8097**

**Person/organizations receiving the information: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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**Specific description of information (including date(s) of service): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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**Section B: Must be completed only if a health plan or a health care provider has requested the information**

1. The health plan or health care provider must complete the following:
	1. What is the purpose of the use or disclosure? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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* 1. Will the health plan or health care provider requesting the authorization receive financial or in-kind compensation in exchange for using or disclosing the information described above?

Yes\_\_\_\_\_\_\_\_ No\_\_\_\_\_\_\_\_

 2. The patient or the patient’s representative must read and initial the following statements:

a. I understand that my health care and the payment for my health care will not be affected if I

 do not sign this form. **INITIALS: \_\_\_\_\_\_\_\_\_\_\_**

**Section C: Must be completed for all authorizations**

The patient or the patient’s representative must read and initial the following statements:

1. I understand that this authorization will expire on \_\_/\_\_/\_\_\_\_ (MM/DD/YYYY) **INITIALS \_\_\_\_\_\_\_\_\_**
2. I understand that I may revoke this authorization at any time by notifying the practice in writing, but if I do, it won’t have any affect on any actions they took before they received the revocation. **INITIALS \_\_\_\_\_**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of patient or patient’s guardian Date

(*Form MUST be completed before signing*)

**Printed name of patient or patient’s guardian \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Relationship to patient \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**\*YOU MAY REFUSE TO SIGN THIS AUTHORIZATION\***