AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

Patient Information

Name: _____

Date of Birth: _____

Social Security Number: _____

Address: _____

Healthcare Provider Authorized to Release Information

I authorize the following person and/or organization to disclose the health information described herein:

Name: CONCIERGE RADIOLOGY CONSULTING

Authorized Recipient of Medical Records

I authorize the following person and/or organization to receive the health information described herein:

Name: _____

Address: _____

Via: Mail { } Fax { }: _____ Email { }:_____

THIS AUTHORIZATION DOES NOT AUTHORIZE YOU TO DISCLOSE MY MEDICAL RECORDS TO ANYONE OTHER THAN THE AUTHORIZED RECIPIENT SPECIFIED HEREIN.

Reason for Release of Information

The release of this information is made at the request of the undersigned individual due who has the appropriate legal authority to request said records. This release and all the provisions contained herein are effective immediately. This release authority applies to any information governed by the Health Insurance Portability and Accountability Act of 1996 (HIPAA), 42 U.S.C. Sections 1320d to 1320d-9 and 45 C.F.R. Sections 164.500 to 164.534, as may be amended from time to time.

I hereby authorize the entity identified above to disclose the following specific information:

- ☐ Entire medical record/clinical/resident record with no date restrictions
- ☐ Record from _____ (beginning date) to _____ (end date)
- ☐ Other: _____

"Medical record" includes patient histories, patient questionnaires, intake information sheets, office notes (except psychotherapy notes), consultations, test results, laboratory reports, radiology studies or reports, pathology reports, x-ray reports, films, diagnostic tests, referrals, medication

records, prescription and pharmacy records, assessments, treatment plans (including treatments prescribed, performed, or recommended), diagnosis or prognosis information, periods of stays or hospitalization, discharge summaries and instructions, progress notes, billing and payment records, insurance records, correspondence, records sent to you by other healthcare providers, computer data or compilations or reports, and all other forms or documents.

"Clinical record" includes patient evaluations, assessments, progress notes, clinical therapy notes, individual sessions notes, treatment plans and clinical psychological diagnosis.

"Resident record" includes legal and financial forms, notices, rental payments, invoices, polices, and procedures and other non-medical or clinical forms and documents maintained in the resident record.

Expiration of Authorization

This authorization shall remain in effect for one year or unless otherwise terminated by providing written notice.

Patient Certification and Acknowledgment of Understanding

I request that health information regarding my care and treatment be released as set forth on this form. I certify that I am the patient and/or authorized representative, and the identification that I have provided is true and correct.

In accordance with Florida Law and the Privacy Rule of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I understand and agree with the following statements:

- **_____: (PATIENT INITIAL) Alcohol and drug abuse, mental health, and HIV-related information.** This authorization may include disclosure of information relating to alcohol and drug abuse, mental health, and HIV-related care, testing, or treatment. I specifically authorize the release of this information to the authorized recipient indicated above.
- **_____: (PATIENT INITIAL) Redisclosure**. I understand that any information disclosed pursuant to this authorization may be redisclosed by the recipient and its confidentiality may no longer be protected by federal or state law.
- **Prior Agreements**. This release shall supersede any prior agreement that I or my authorized representative may have made with my health-care providers to restrict access to or disclosure of my individually identifiable health information. The individually identifiable health information and other medical records given, disclosed, or released may be subject to re-disclosure by the party designated and may no longer be protected by HIPAA.
- **Revocation**. I have the right to revoke this authorization, in writing, at any time, except to the extent that the healthcare provider identified above has acted in reliance upon it, by sending written notification to the healthcare provider identified above.
- **Authorization is voluntary**. I understand that signing this authorization is voluntary.

- **Copy**. I agree that a copy of my signature will be treated as an original signature, and I understand that I have received a copy of this authorization.
- **_____: (PATIENT INITIAL) Limitation of Liability**.

  CONCIERGE RADIOLOGY CONSULTING, acting in reliance on this Release, shall be released from any and all liability that may result from disclosing my individually identifiable health information and other medical records under HIPAA and/or Fla. Stat. 456.057.

Signature	
Name	
Date	
Title	
Address	
Telephone	
Email	