Radiology Imaging Associates

Administrative Offices
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AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH CARE INFORMATION

By signing this form, I, _____, authorize the use and disclosure by RIA of the protected health information of

(patient's name) _____

1. **Description of information**: Medical imaging records, radiographs, physician interpretations, reports, billing information and referrals / scripts (circle what applies), or other information (insert here): _____ For date of service: _____

2. **Name or identification of person(s) authorized to receive the information**: _____

3. **Description of each purpose of the requested use or disclosure**: (Check applicable purpose below, and have patient initial each corresponding lettered purpose.)

   __ At the request of the patient, personal representative or responsible party: (Initial "a" below.) _____
   __ For clinical research: (Initial "b" below.) _____
   __ For fitness-for-duty exam, or insurance requirement: (Initial "c" below.) _____
   __ Other purpose, please describe: (Initial "a," "b," or "c" below.) _____

   a. _____ [Initials of patient, responsible party or personal representative] **I understand that RIA may not condition future treatment on my signing this authorization and that I have a right to refuse to sign it.**

   b. _____ [Initials of patient, responsible party or personal representative] **I understand that RIA may condition my treatment, which is furnished in connection with clinical research on my signing this authorization. If I do not sign the authorization, RIA may refuse to provide such treatment.**

   c. _____ [Initials of patient, responsible party or personal representative] **I understand that RIA may condition my treatment on my signing this authorization to provide information, which was requested by the third party identified in number 2 above. If I do not sign the authorization, RIA may refuse to provide such treatment.**

4. **Date or event when authorization expires**:_____

I understand that I have the right to revoke this authorization, in writing, at any time, except where uses or disclosures have already been made based upon my original permission or if the permission is a condition of obtaining insurance coverage. I understand that uses and disclosures already made based upon my original permission cannot be taken back. To revoke this authorization, I must do so in writing and send it to RIA, Attention: Billing Manager, 7801 Old Branch Avenue, Suite 300, Clinton, MD 20735.

I understand that it is possible that information used or disclosed with my permission may be re-disclosed by the recipient and no longer protected by the Federal Privacy Standards.

I understand that any films signed out are the property of RIA. I agree to arrange for the return of any films within 30 days of sign-out. I agree to accept full responsibility for any loss or damage to films during the period that the films are not within the sole, exclusive possession of RIA.

_____ _____
Signature of patient, responsible party, or personal representative** Date

_____ _____
Print name of patient, responsible party, or personal representative RIA Witness

** If an authorization is signed by the patient's personal representative (other than if the patient is a minor child), the representative's authority is based on: _____ (e.g., state law, court order, etc.).

For Office Use Only:

Requested pick-up date: _____ Time: _____ Today's date: _____

DOB:_____ SSN: _____ X-ray #:_____ LDOS: _____ Phone # _____

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