Complete Image

Authorization for Use and Disclosure of Protected Health Information

I hereby authorize Complete Image to use and/or disclose my protected health information as described below to

(name and address of recipient)

_____

_____

for the following purposes: **(describe each purpose of use/disclosure - If disclosing different types of information below for different purposes, the authorization must specify the purpose for which each type of information is being disclosed.)**

I understand that:

1) **THIS AUTHORIZATION IS VOLUNTARY AND I MAY REFUSE TO SIGN THIS AUTHORIZATION WITHOUT AFFECTING MY HEALTH CARE OR THE PAYMENT FOR MY HEALTH CARE**
2) I have the right to request a copy of this form after I sign it as well as inspect or copy any information to be used and/or disclosed under this authorization (if allowed by state and federal law. See 45 CFR § 164.524).
3) I may revoke this authorization at any time by notifying Complete Image in writing as set forth in the Notice of Privacy Practices. However, it will not affect any actions taken before the revocation was received or actions taken in reliance thereon, or if the authorization was obtained as a condition of obtaining insurance coverage and other applicable law provides the insurer with the right to contest a claim under the policy.
4) Complete Image agrees to maintain the confidentiality of my protected health information; however, if the person or organization authorized to receive the information is not a health plan, health care clearinghouse or health care provider, federal law (HIPAA) requires me to be advised that information used or disclosed pursuant to this authorization may be subject to re-disclosure and may no longer be protected by HIPAA rules.

Marketing:

☐ If this box has been checked by the practice, I understand that the practice will receive compensation for using or disclosing my information for marketing purposes.

Type of Information to Be Disclosed

☐ Entire Medical Record	☐ Most Recent 5 Year History	☐ Radiology Reports
☐ Office Chart Notes	☐ All Hospital Records	☐ Operative Reports
☐ Billing Statements	☐ Transcribed Hospital Reports	
☐ Dental Records	☐ History and Physical Exam	☐ Other _____
☐ Laboratory Reports	☐ Emergency and Urgent Care Records	
☐ Pathology Reports	☐ Medical Records for Continuity of Care	_____
☐ Consultation	☐ Diagnostic Imaging Reports	
☐ Discharge Summary	☐ Emergency Room Reports	_____

Expiration:

This authorization will expire 180 days from the date of signing or **(insert date)** 04/12/2021.

Patient Name: _____ **Patient ID #:** _____

_____ 04/12/2021

Signature of Patient or Legal Representative **Date**

_____ **Relationship to Patient (*if applicable*)**

Printed Name of Patient's Representative (*if applicable*)

☐ Parent or guardian of unemancipated minor
☐ Court appointed guardian
☐ Executor or administrator of decedent's estate
☐ Power of Attorney

_____ 04/12/2021

Signature of Witness **Date**

Complete Image

Authorization to Release Information to Family Members

Many of our patients allow family members such as their spouse, significant other, parents or children to call and request the result of tests, procedures and financial information. Under the requirements for H.I.P.A.A. we are not allowed to give this information to anyone without the patient's consent. If you wish to have your medical information, any diagnostic test results and/or financial information released to any family members you must sign this form.

You have the right to revoke this consent, in writing, except where we have already made disclosures in reliance on your prior consent.

I authorize Complete Image to release my records and any protected health information requested to the following individuals.

1. _____ Relation to Patient: _____

2. _____ Relation to Patient: _____

for the following purposes: **(describe each purpose of use/disclosure - If disclosing different types of information below for different purposes, the authorization must specify the purpose for which each type of information is being disclosed.)**

☐ at request of individual

_____

Expiration:
This authorization will expire 180 days from the date of signing or _____.

Patient Name: _____ **Patient ID #:** _____

_____ 04/12/2021
Signature of Patient or Legal Representative **Date**

Relationship to Patient (*if applicable*)
☐ Parent or guardian of unemancipated minor
☐ Court appointed guardian
☐ Executor or administrator of decedent's estate
☐ Power of Attorney

_____
Printed Name of Patient's Representative (*if applicable*)

_____ 04/12/2021
Signature of Witness **Date**