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.

I authorize payment of medical benefits directly to the physician for services rendered.
I understand that I am responsible for all co-payments, coinsurance and services deemed “non-covered” by my insurance.
I authorize my physician to act as my agent in assisting me to obtain payment from my insurance companies.

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

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

_____ _____
Signature of Patient or Legal Representative **Date**

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

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

_____ _____
Signature of Witness **Date**