## Imaging Specialists Patient Authorization for Disclosure of Health Information

Patient Name: _____ Date of Birth: ___ / ___ / ___

Last 4 digits of Social Security Number: _____
Prior Facility Name: _____
City: _____ State: _____ Fax: _____ Phone: _____

I request that my protected health information (PHI) be disclosed to:
Recipient Name: Imaging Specialists
1241 Woodland Ave
Mount Pleasant, SC 29464
Phone: 843-881-4020 Fax: 843-284-4279

I authorize the following PHI to be released from my medical records(s):

_____

_____

Images and reports covering the period of healthcare from (Specific Dates) _____ to: _____

I understand that the information in my health record may include information relating to sexually transmitted disease (STD), acquired lmri1unodefiderícy syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment of alcohol or drug abuse.

Purpose for requesting information: Continuation of Care Disclosure
Format: US Mail and/or Fax (healthcare provider only)

By signing this authorization form, I understand that:

- I have the right to revoke this authorization. at any time. Revocation must be made in writing and presented or mailed to the Health Information Management department. Revocation will not apply to information that has already been disclosed in response to this authorization.
- Unless otherwise revoked, this authorization will expire on the following date/event/condition:_____ If I fail to specify a expiration date/event/condition, this authorization will expire (time frame) _____ from date signed.
- Treatment, payment, enrollment, or eligibility for benefits may not be conditioned on whether I sign this authorization.
- Any disclosure of information carries with it the potential for unauthorized redisclosure, and the information may not be protected by federal confidentiality rules.

_____

Patient or Authorized Representative Signature Date

_____

Print Name and Relationship to Patient (if applicable)