# 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

Address: 1241 Woodland Ave City: Mount Pleasant State: SC Zip: 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 Immunodeficiency 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 an 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)