S A R A
Southern Arizona Radiology Associates

Southern Arizona Radiology Associates
520-335-6849 (ph) 520-459-2191 (f)
www.sararadiology.com

AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

Patient's Legal Name: _____ DOB:_____/_____/_____
Address: _____City:_____ State: _____ Zip:_____
Primary Telephone Number: _____ Alternate Telephone Number: _____

Purpose of the Requested Use or Disclosure (check one): ____ Continuing Medical Care; ____ At My Request; ____ Filing Insurance Appeal; ____ Other: _____

I hereby authorize Southern Arizona Radiology Associates (SARA) to release to the recipient identified below, a copy of the following protected health information, including any confidential HIV/AIDS-related information, confidential communicable disease-related information, and/or information relating to any mental health and/or alcohol/drug use:

- ☐ Orders
- ☐ Images (CD)
- ☐ Radiology Reports
- ☐ Correspondence
- ☐ Other: _____
- ☐ Entire Record

Recipient: _____ Contact Person:_____
Address: _____City:_____ State: _____ Zip:_____
Telephone Number: _____ Fax Number: _____

I understand that I may revoke this authorization at any time by notifying SARA in writing, except to the extent that action based on this authorization has already been taken. Unless revoked, this authorization will expire on _____. If no date is provided it shall automatically expire six (6) months from the date on which it is signed. I agree to allow SARA to send the information to be released by fax or electronically.

Notice: SARA may not condition treatment, payment, enrollment or eligibility for benefits on whether you sign this authorization. Information disclosed pursuant to this authorization may be subject to redisclosure by the Recipient and may no longer be protected by federal privacy laws.

_____ **Date: _____/_____/_____**
Patient/Representative* signature

*If you are a Personal Representative, you must provide a description of your authority to act for the patient.

INTERNAL USE ONLY
Note: SARA's receipt of payment for records is authorized by law in certain circumstances.
Date payment received____/____/____ Amount received:_____ Check Cash CC

Date records sent/picked up by patient___/____/____ Sent By:_____