Southern Arizona Radiology Associates
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www.sararadiology.com

AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION TO SOUTHERN ARIZONA RADIOLOGY ASSOCIATES

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: _____

Releasing Facility/Practice: _____ Contact Person:_____
Address: _____City:_____ State: _____ Zip:_____
Telephone Number: _____ Fax Number: _____

I hereby authorize the releasing facility/practice identified above to release and disclose *to* Southern Arizona Radiology Associates, a copy or an original 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

I understand that I may revoke this authorization at any time by notifying the releasing facility/practice 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 the releasing facility/practice to send the information to be released by fax or electronically.

Notice: The releasing facility/practice 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