HIPAA PRIVACY AUTHORIZATION FORM

Authorization to Disclose and/or Request Protected Health Information

Patient Name:____

Date of Birth:_______/_______/_______Phone number:____

I ____hereby authorize Advanced Shore Imaging Associates to disclose and/or request Protected Health Information (PHI) from my medical record(s) relating to my diagnostic study(s) to:

Name:____Relationship_____________________

Name:____Relationship_____________________

I hereby acknowledge receipt of Advanced Shore Imaging Associates Notice of HIPAA Privacy Practices/Joint HIPAA Privacy Notice. I understand this consent serves as a complete release of liability to Advanced Shore Imaging Associates and its employees for the release of information, and/or digital media (CDs) or films. I understand that I have the right to revoke this authorization, in writing at any time. I understand the revocation is not effective to the extent that any person or entity has already acted in reliance on my authorization or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim. Unless otherwise revoked, this authorization shall be in force and effect one year from today's date at which time authorization expires.

____ ____________________________
Signature of Patient (or Legal Representative) Date

Revised 7-23-20