RADIOLOGY LTD., P.L.C. and RLC, LLC

677 North Wilmot Road
Tucson, Arizona 85711

AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

Patient's Legal Name:____
Address:____DOB______________________
City:____State:______________________Zip Code:__________________

Purpose of the Requested Use or Disclosure is: _______ Continuing Medical Care _______ At My Request
_______ Proctoring Medical Students _______ For Medical Publication and Educational Purposes
_______ Marketing _______ Insurance Verification _______ Other: ___________________________________

I hereby authorize Radiology Ltd. to release to the Recipient identified below, the following protected health information:

_______Initial Examination
_______Progress Notes
_______Laboratory Reports
_______X Ray reports
_______Other (please specify below)

_______Consultations
_______Hospital Records
_______EKG
_______X Ray films
_______ Entire Chart
_______ Speak to about my healthcare

(Other)____

Recipient:____
Address:____
City:____State:______________________Zip Code:__________________
Fax No.__________________________________Contact Person:____

I understand that I may revoke this authorization at any time by notifying Radiology Ltd./RLC 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 one year from the date on which it is signed. I agree to allow information to be faxed if necessary.

Notice: Except as permitted by law, Radiology Ltd./RLC 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 re-disclosure by the Recipient and may no longer be protected by federal privacy laws.

____ __________________________________
Signature of Patient/Personal Representative* Date

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

____
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Crystal C. Atwell HIPAA Privacy/Security Officer, @ 677 N. Wilmot Rd., Tucson, AZ. 85711 or E-Mail to: crystal.atwell@radltd.com

INTERNAL USE ONLY

Date payment received_______________Amount received___________________ Check Cash CC

Date records sent__________________________Sent By____

Filename: Authorization Form Word

WE TAKE CARE OF THOSE CLOSEST TO YOU.
A TUCSON TRADITION FOR MORE THAN 80 YEARS 80