Authorization for Disclosure of Health Information

This form is used to release your protected health information as required by federal and state privacy laws. Your authorization allows identified entity to release your protected health information to a person or organization that you choose.

SECTION A: PATIENT INFORMATION			
Name:	DOB:	Phone #:	
Address:	City:	State:	Zip Code:

SECTION B: Identified Entity(office that will release your information)
I authorize Fort Washington Radiological Assoc (VIBB) to release my PHI as described below.

SECTION C: Recipient of Health Info(usually your PCP or another physician office)			
Name/Office:	Phone #:		
Address:	City:	State:	Zip Code:

SECTION D: Description of Information to be released
☐ All information related to the continuation of medical care ☐ Specific info:_____ _____

SECTION E: Purpose of Release (circle one)
Patient's request Continuity of care Payment of bill Legal Worker's Compensation Other_____ *If you do not indicate, a default of patient's request will be used

SECTION F: Expiration
This authorization will expire upon the completion of medical care. ** You may revoke this authorization at any time by submitting a request in writing to the entity identified in Section B. Revoking this authorization will not apply to any info that has already been released.

SECTION G: Approval
I understand that this authorization to release information is voluntary and that my refusal to sign this authorization will not affect my ability to receive treatment.

Patient Signature:	Representative Name(if needed):
Print Name:	Relationship to Patient:
Date:	Signature: Date: