AUTHORIZATION OF USE & DISCLOSURE OF PROTECTED HEALTH INFORMATION

DESERT RADIOLOGY
a radiology partners practice

OFFICE USE ONLY – Patient PID: _____

Patient Name:_____ DOB: _____

I authorize Desert Radiology the use and disclosure of Protected Health Information. My personal identifying information is as listed above. The information to be used and disclosed covered by this authorization includes medical records, films, billing information, etc.

Family Member/Persons/Group to whom information may be disclosed: (Name / Address / Phone or Fax #)

_____

Name Address Phone / Fax

The Protected Health Information will be Used and Disclosed as follows: (check box that applies)

☐ Request of the patient ☐ Other: _____

This authorization is effective through_____(mm/dd/yyyy) unless revoked or terminated by the patient or the patient's personal representative. You may revoke or terminate this authorization by submitting a written revocation to Desert Radiology. You should contact the Medical Records Department (702.759.8750) to terminate this authorization. Revocation will exclude disclosures made prior to effective date of revocation. Please note that the person or organization to which we disclose PHI may further disclose information that is disclosed under this authorization. The privacy of this information may not be protected under the federal privacy regulations.

Request for Protected Health Information from another Provider (Privacy Rule 45 CFR 164.506)

In an effort to obtain continuation of care without any delay, I authorize the following health care providers to release any and all necessary health care information to Desert Radiology:

Provider Name: _____

Provider Address: _____

Provider Phone: _____ Provider Fax: _____

Please send records to the medical records department at:
Desert Radiology
Attn: Medical Records Department
3930 S. Eastern Avenue
Las Vegas, NV 89119

Desert Radiology will not condition treatment on whether the patient signs this authorization unless the treatment is research related or the treatment is for the purpose of creating PHI for disclosure to a third party such as life insurance or for disability examinations.

_____

Signature of Patient/Patient's Representative Date

_____

Relationship to Patient