

**RADIOLOGY ASSOCIATES OF OCALA
PATIENT AUTHORIZATION FOR USE AND DISCLOSURE
OF PROTECTED HEALTH INFORMATION**

By signing this authorization, I authorize Radiology Associates of Ocala to use and/or disclose certain protected health information (PHI) about me to _____.

(Person or Entity to receive the information)

This authorization permits Radiology Associates of Ocala to use and/or disclose the following individually identifiable health information about me (specifically describe the information to be used or disclosed, such as date(s) of service, level of detail to be released, origin of information, etc.).

The information will be used or disclosed for the following purpose: _____. If requested by the patient, purpose may be listed as “at the request of the individual.” The purpose(s) is/are provided so that I can make an informed decision whether to allow release of the information. This authorization will expire on

_____.

(Expiration Date or Defined Event)

The Practice will not receive payment or other remuneration from a third party in exchange for using or disclosing the PHI.

I do not have to sign this authorization in order to receive treatment from Radiology Associates of Ocala.

In fact, I have the right to refuse to sign this authorization. When my information is used or disclosed pursuant to this authorization, it may be subject to redisclosure by the recipient and may no longer be protected by the federal HIPAA Privacy Rule. I have the right to revoke this authorization in writing except to the extent that the practice has acted in reliance upon this authorization.

My written revocation must be submitted to the Privacy Officer at: PO Box 6200, Ocala, FL 34478-6200

Signed by: _____

Signature of Patient or Legal Guardian

Relationship to Patient

Print Patient's Name - SSN

Date

Print Name of Patient or Legal Guardian

Notary Signature and Stamp