Authorization for Use and Disclosure of Health Information

I, Patient Name: _____ Patient DOB: _____give permission to WNY Imaging Group and it's sister companies(Kenton Open MRI,P.C, WNY Pet/CT,L.L.C., WNY MRI,L.L.C, Lockport MRI, WNY Women's Imaging, Rainbow Imaging Associates, L.L.P and Amherst Diagnostic Imaging, P.C,) to :

_____Disclose the following protected health information to:_____
_____ All Health Information(Reports & Images)
_____ Health Information for the date(s)._____
Please enter any other name(s)/entities to **receive** information:
_____
_____

By signing this form, I hereby authorize WNY Imaging Group and it's sister companies to **obtain** the Health Information described below from _____.

_____ All Health Information(Reports & Films)
_____ Health Information for the date(s)._____

REASON FOR THIS AUTHORIZATION

THIS AUTHORIZATION EXPIRES UPON: One year from date of signature.

I understand that I may refuse to sign this authorization. Treatment, payment, enrollment in a health plan or eligibility for benefits will not be conditioned on signing an authorization if to do so would be prohibited by federal or state law. I understand an authorization may be required to participate in research or where health care services are provided solely for the purpose of creating health information for a third party, and that if I refuse to sign an authorization those services may be denied.

I may revoke this authorization in writing. If I do, it will not effect any previous actions already taken in reliance upon my authorization. I may not be able to revoke this authorization if its purpose was to obtain insurance. I may revoke this authorization by writing a letter and mailing it by certified mail, return receipt requested, to the Privacy Officer at the health care provider listed above.

Once health information is disclosed pursuant to this authorization, it may be re-disclosed and may no longer be protected by privacy laws.

I have been offered a copy and I understand the HIPAA Compliance Act.

Patient/Legally Auth. Rep.Signature: _____

Witness Signature: _____ Date: _____