702-382-XRAY

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STANDARD AUTHORIZATION OF USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

I, ______________________________, authorize Desert Radiologists the use and disclosure of Protected Health Information. My personal identifying information is as follows:

Patient Name: ______________________________ **Phone #**: ______________________

Date of Birth: ______________________ **Social Security #**: ______________________

Information to be Used and Disclosed:
The information covered by this authorization includes: (Medical records/films/billing information/etc.)
☐ Report (no charge) ☐ CD (no charge) ☐ Film ($15 per sheet) **Exam:** ________________ **Exam Date**:__________

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

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

- ☐ At the request of the patient
- ☐ Other ____

Expiration Date of Authorization:
This authorization is effective through ______________ (mm/dd/yyyy) unless revoked or terminated by the patient or the patient's personal representative.

Right to Terminate or Revoke Authorization and Potential for Re-Disclosure:
You may revoke or terminate this authorization by submitting a written revocation to Desert Radiologists. You should contact the Compliance Department (702/382-3843 x 3444) to terminate this authorization. Revocation will exclude disclosures made prior to effective date of revocation. Please note that the person or organization to whom 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. Desert Radiologists 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.

I understand that once I remove my original mammogram films from Desert Radiologists they will NOT retain a copy in my file. I further acknowledge that it is my responsibility to return said films back to Desert Radiologists as soon as possible.

______________________________________ ______________________
Patient's Printed Name Date

______________________________________ ______________________
Signature of Patient or Patient's Representative Relationship to Patient