Tri-City Radiology, Inc. P.S.
Authorization to Use or Disclose Protected Health Information

Patient name: _____ **Date of birth:** _____

Previous name (s):_____

From: Tri-City Radiology, Inc. P.S 7221 W Deschutes Ave. Suite A. Kennewick, WA. 99336

Phone: 509-374-4030 Fax: 509-374-8690

I. My Authorization

You may use or disclose the following health care information (check all that apply):

___All health care information in my medical record

___ Health care information in my medical record relating to the following treatment or condition:

_____

___ Health care information in my medical record for the date(s): _____

___ Other (e.g., X-rays, bills), specify date(s): _____

You may use or disclose health care information regarding testing, diagnosis, and treatment for (check all that apply):

___ HIV (AIDS virus) ___ Sexually transmitted diseases

___ Psychiatric disorders/mental health ___ Drug and/or alcohol use

You may disclose this health care information to: _____

_____

_____

_____

This authorization ends:

___on (date): _____when the following event occurs: _____

___ in 90 days from the date signed (if disclosure is to a financial institution or an employer of the patient for purposes other than payment)

II. My Rights

I understand I do not have to sign this authorization in order to get health care benefits (treatment, payment, or enrollment). However, I do have to sign an authorization form:

- To take part in a research study **or**
- To receive health care when the purpose is to create health care information for a third party.

I may revoke this authorization in writing. If I did, it would not affect any actions already taken by ***Tri-City Radiology, Inc. P.S*** based upon this authorization. I may not be able to revoke this authorization if its purpose was to obtain insurance. Two ways to revoke this authorization are:

- Fill out a revocation form. A form is available from ***Tri-City Radiology, Inc. P.S*** **or**
- Write a letter to ***Tri-City Radiology, Inc. P.S***

Once health care information is disclosed, the person or organization that receives it may re-disclose it. Privacy laws may no longer protect it.

_____

Patient or legally authorized individual signature Date Time

_____

Printed name if signed on behalf of the patient Relationship (parent, legal guardian, personal representative)