PREFERRED OPEN MRI

HIPAA Privacy Authorization Form

To: _____

(Name of Health Care Facility, Physician, Agency, etc.)

_____

(Street Address, City, State and Zip Code)

***Phone Number*: _____ *Fax Number*: _____**

RE: **Patient Name:** _____

Date of Birth: _____ Address: _____

I hereby authorize **Preferred Open MRI** to use and disclose the protected health information described below.

☐ The complete medical record, excluding mental health treatment, alcoholism treatment, drug abuse treatment, and HIV/acquired immune deficiency syndrome (AIDS) records.

☐ The medical record covering the period of healthcare from _____ to _____.

The purpose(s) of this authorization is (are) _____.

I understand that I have the right to inspect and copy the information I have authorized to be disclosed by this authorization. In the event I refuse to authorize the release of the above described information, I understand that it will not be disclosed except as provided by law.

I understand that the practice may not condition treatment on whether I sign this authorization, except when the provision of health care is solely for the purpose of creating protected health information for disclosure to a third party.

I understand that information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by law.

I understand that this authorization is valid until it expires, unless revoked before that.

I understand that I have the right to revoke this authorization at any time. I understand the revocation must be in writing and bear my signature and date. My revocation must be submitted to the above healthcare provider. I understand that if I do revoke this authorization, my revocation will not affect any prior actions taken in reliance on this authorization.

This HIPAA Privacy Authorization Form will terminate on _____(*Date)*.

Signed: _____ Date: _____

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