AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

Section A: Must be completed for all authorizations
I hereby authorize the use and disclosure of my individually identifiable health information as described below. I understand that this authorization is voluntary. I understand that if the organization authorized to receive the information is not a health plan or health provider; the released information may no longer be protected by federal regulations.

Patient name:_____ **ID/Acct Number:**_____

SS# _____

Persons/organizations providing the information: **Diagnostic Radiology Imaging, LLC**
1150 Revolution Mill Drive,
Suite 9, Greensboro, NC
27405 Phone: 336-433-5000

Person/organizations receiving the information: _____
_____
_____

Specific description of information (including date(s) of service) _____
_____
_____

Section B: Must be completed only if a health plan or a health care provider has requested the information

1. The health plan or health care provider must complete the following:
   a. What is the purpose of the use or disclosure? _____
      _____
   b. Will the health plan or health care provider requesting the authorization receive financial or in-kind compensation in exchange for using or disclosing the information described above?
      Yes_____ No_____
2. The patient or the patient's representative must read and initial the following statements:
   a. I understand that my health care and the payment for my health care will not be affected if I do not sign this form. **INITIALS:** _____

Section C: Must be completed for all authorizations
The patient or the patient's representative must read and initial the following statements:

1. I understand that this authorization will expire on __/__/____ (MM/DD/YYYY) **INITIALS** _____
2. I understand that I may revoke this authorization at any time by notifying the practice in writing, but if I do, it won't have any affect on any actions they took before they received the revocation. **INITIALS**_____

_____ _____
Signature of patient or patient's guardian Date
(*Form MUST be completed before signing*)

Printed name of patient or patient's guardian _____

Relationship to patient _____

YOU MAY REFUSE TO SIGN THIS AUTHORIZATION