AUTHORIZATION FOR USE OR DISCLOSURE OF PATIENT PROTECTED HEALTH INFORMATION (PHI)

ADVANCED IMAGING OF LAFAYETTE

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***"Protected Health Information"* (PHI)** is information about you, including demographic information, that may identify you and that relates to your past, present or future health and related health care services. Consistent with our Notice of Privacy Practices, Alliance Imaging, Inc., its subsidiaries and affiliates (**Advanced Imaging of Lafayette**) are required to obtain your authorization to permit the following use or disclosure of your PHI. Advanced Imaging will not condition your treatment on whether you provide authorization for the requested use or disclosure.

I,_____, hereby authorize **Advanced Imaging / Alliance** to (check those that apply):

- ☐ Use the following PHI (described below), and/or
- ☐ Disclose the following PHI to: _____

The specific Protected Health Information to be used or disclosed under this authorization is: (Include relevant detail such as patient name (if authorization is being granted by patient's personal representative), date of service, type of service provided, level of detail to be released, name of documents or information, original source of information, etc.)

I authorize the use or disclosure of the PHI specified above for the following purposes:

This authorization shall be in force and effect until _____ or 45 days from the date of my signature below, whichever is later, at which time authorization for Alliance to use or disclose the specified PHI expires.

I understand that I have the right to revoke this authorization at any time by sending such written notification to the Advanced Imaging of Lafayette - Alliance Imaging Health Information Liaison via mail to: Alliance Imaging, Inc.; Attn: Health Information Liaison; 1900 S. State College Boulevard; Suite 600; Anaheim, CA 92806. Such a revocation will not be effective to the extent that Alliance Imaging has relied on it for the previous use or disclosure of the PHI.

I understand that information used or disclosed pursuant to this authorization **may be subject to re-disclosure by the recipient and may no longer be protected** by federal or state law.

I understand that I have the right to refuse to sign this authorization and that I am entitled to receive a copy of this authorization, if signed.

_____ _____
Signature of Patient or Personal Representative | Date of Authorization/Signature

_____ _____
Name of Patient or Personal Representative | Description of Personal Representative's Authority

_____ _____
Patient Account # or SSN | Patient Address

For Advanced Imaging/ Alliance Imaging Use Only

Employee Initials_____ Site/Office_____ r 3/21/03