HIPAA Authorization for Disclosure of Protected Health Information

To any physician, health care professional, dentist, health plan, hospital, clinic, laboratory, pharmacy, or other covered health care provider, any insurance company, and the Medical Information Bureau, Inc., or other health care clearinghouse that is providing or has provided or proposes to provide treatment or services to me or payment for such treatment or services, or that is seeking payment from me for treatment or services:

I, _____, birth date _____,

whose address is _____, state as follows:

1. **Authorization.** I authorize you to give, disclose, and release to Coolidge Imaging, LLC or its employees, billers, agents, assignees, attorneys, without restriction, all of my individually identifiable health information and medical records and all other information regarding my past, present, or possible future medical, dental, or mental health condition or treatment. This also includes the broadest possible right to discuss any such information with my with them that could be discussed with me personally. This authority shall supersede any prior agreement that I may have made to restrict access to or disclose my individually identifiable health information.
2. **When and how to provide information.** You are authorized to provide the information identified in this document at any time and from time to time at the request of any one or more of the individuals identified in Paragraph 1 above. It may be provided by direct in-person discussion, or by e-mail, phone, fax, or any other type of communication. You may assume that whoever is communicating with you by telephone, e-mail, fax, or other type of communication is the person as represented by that individual.
3. **Expiration.** This authorization will expire one year from the date signed.
4. **Authority to revoke.** I reserve the right to revoke this authorization. In order to revoke this authorization, the notification must be written, signed by me, and dated, and delivered to you.
5. **Redisclosure.** I understand that the information disclosed by reason of this document may be subject to redisclosure by the recipient and therefore may no longer be protected under state or federal law.
6. **Copies.** A copy of this Authorization shall be considered as effective and valid as the original.
7. **Voluntary action.** I understand I am not required to sign this document, and I am voluntarily doing so.
8. **Privacy waiver.** With regard to the disclosure of information authorized in this document, I waive any right of privacy that I may have under the authority of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), Public Law 104-191, that might otherwise prevent any person or entity to whom this release is delivered from providing access to my medical records or other information authorized to be released under this document, and I hold harmless from any claim of liability under such act, rule, or regulation any person or entity who provides information or access to my medical information and records under this document.

Dated: _____ _____ _____

Signature Print Name