SOUTHERN ARIZONA RAD ASSOCIATES, LLC
D/B/A SIERRA VISTA DIAGNOSTICS

155 Calle Portal, Suite 500
Sierra Vista, AZ 85635
(520) 459-5227 (t)
(520) 459-2191 (f)

AUTHORIZATION FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION ***TO*** SOUTHERN ARIZONA RAD ASSOCIATES, LLC D/B/A SIERRA VISTA DIAGNOSTICS

Patient's Legal Name:_____M.R. #:_____
Address:_____DOB: _____
City:_____State:_____Zip Code:_____
Primary Telephone No.:_____ Alternate Telephone No.:_____

Purpose of the Requested Use or Disclosure (check one): _____ Continuing Medical Care; ____ At My Request;_____ Filing Insurance Appeal; ____ Other: _____

Releasing Facility/Practice: _____
Address: _____
City: _____State: _____Zip Code: _____
Fax No.: _____Contact Person: _____

I hereby authorize the Releasing Facility/Practice identified above to release and disclose ***to*** Southern Arizona Rad Associates, LLC d/b/a Sierra Vista Diagnostics ("SVD"), a copy or an original of the following protected health information, including any confidential HIV/AIDS-related information, confidential communicable disease-related information, and/or information relating to any mental health and/or alcohol/drug use:

_____Orders
_____Radiology Reports
_____Correspondence
_____Entire Record
_____Images
_____Films
_____Other (please specify below)

(Other)_____

I understand that I may revoke this authorization at any time by notifying the Releasing Facility/Practice in writing, except to the extent that action based on this authorization has already been taken. Unless revoked, this authorization will expire on _____. If no date is provided it shall automatically expire six (6) months from the date on which it is signed. I agree to allow SVD to send the information to be released by fax or electronically.

Notice: The Releasing Facility/Practice may not condition treatment, payment, enrollment or eligibility for benefits on whether you sign this authorization. Information disclosed pursuant to this authorization may be subject to redisclosure by SVD and may no longer be protected by federal privacy laws.

_____ _____
Signature of Patient/Personal Representative Date

*If you are a Personal Representative, you must provide a description of your authority to act for the patient.

_____
_____
_____

INTERNAL USE ONLY

Date records received by SVD _____