Authorization for Use and Disclosure of Protected Health Information

I, _____, hereby authorize High Tech Imaging Center Inc. to disclose the following protected health information to:

_____ _____

_____ _____

___Records-Reports related only to the following dates of service_____
___Records and original films related only to the following dates of service_____
___Complete medical history (**reports**) with High Tech Imaging Center Inc.

This protected health information is being released for the following purposes:

___Treatment by another physician other than the referring physician
___Transfer of records to complete health records or information at another entity other than the referring physician.
___Attorney
___Other_____

I understand that High Tech Imaging Center Inc. may release my medical records to any physician that I may be under the care of in the future.

I understand that I have a right to revoke this authorization, in writing, at any time by sending such written notification to the Privacy Officer at 1602 Forest Avenue, Montgomery, AL 36106. I understand that a revocation is not effective to the extent that High Tech Imaging Center Inc. has relied on the use or disclosure of the protected health information. I understand that the 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 may refuse to sign this authorization and that my refusal to sign in no way affects my treatment, payment, and enrollment in a health plan, or eligibility for benefits.

I understand that 1. I have the right to inspect or obtain a copy of the protected health information to be used or disclosed as permitted under federal law (or state law to the extent the state law provides greater access rights) .2. Refuse to sign this authorization.

This authorization expires one-year from the date signed or the date the following event occurs:

_____
Signature of Patient or Personal Representative

_____
Patients Address

_____
Patient date of birth and social security number