



**Authorization for the Use or Disclosure of Protected Health Information**

Patient Name: \_\_\_\_\_  
Previous Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_  
ID#: \_\_\_\_\_

I hereby authorize Vancouver Radiologists to use or disclose my Protected Health Information (PHI) in the following manner:

- Release to:

Name of Facility/Provider: \_\_\_\_\_

Mailing Address of Facility/Provider: \_\_\_\_\_

Phone Number of Facility/Provider: \_\_\_\_\_

*OR (Name and address of entity to receive information)*

- Request from:

Name of Facility/Provider: \_\_\_\_\_

Mailing Address of Facility/Provider: \_\_\_\_\_

Phone Number of Facility/Provider: \_\_\_\_\_

*(Name and address of entity VanRad is requesting from)*

The following Protected Health Information:

\_\_\_\_\_ *(Describe the information to be used or disclosed, including descriptors such as date of service, type of service, level of detail to be released or other specific information)*

This Protected Health Information is being used or disclosed for the following purpose(s): treatment, billing, normal operations and facilitating the continuum of care.

This authorization is in full force and effect for 90 days unless otherwise specified in writing.

I understand that I have the right to revoke this authorization in writing by sending notification to the Vancouver Radiologists, PC, Medical Records at the address indicated below. I understand if I revoke this authorization, it is not effective to the extent that Vancouver Radiologists has already relied on the use or disclosure of the PHI.

\_\_\_\_\_  
*Signature (patient or personal representative)*

\_\_\_\_\_  
*Date*

\_\_\_\_\_  
*Printed Name of Patient or Personal Representative*

\_\_\_\_\_  
*Description of Personal Representative's Authority*

\*Send all completed authorization forms to: VANCOUVER RADIOLOGISTS, PC  
MEDICAL RECORDS, SUITE 104  
4201 NE 66<sup>th</sup> AVE  
VANCOUVER, WA 98661  
OR FAX TO: 360-882-1007

Please call 360-254-4914 with any questions.