Authorization for the Use or Disclosure of Protected Health Information

Patient Name: _____
Date of Birth: _____ MR#: _____

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:_____

(Name and address of entity to receive information)

OR

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, and/ or other specific information.)

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

I understand that I have the right to revoke this authorization in writing by sending notification to Vancouver Radiologists, PC 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
Attn: Health Information Management
4816A NE Thurston Way
Vancouver, WA 98662
Phone: 360-254-4914
OR FAX TO: 360-882-1007