UNIVERSITY RADIOLOGY

AUTHORIZATION TO DISCLOSE PATIENT INFORMATION

Purpose:
This form is to be used for including, but not limited to: patient's telephone, fax or mail requests for films, reports or disclosures and for non-TPO requests.

I, _____ hereby authorize University Radiology Group to disclose my health information described below to:

Recipient Name: _____

Recipient Address: _____

Recipient Telephone Number: _____

Films/Documents/Information To Be Released: _____

_____

Purpose of Disclosure (explain or indicate "at the request of the individual"): _____

_____

I understand that the terms of this authorization are governed by the Health Insurance Portability and Accountability Act of 1996, and it's implementing regulations ("HIPAA"). I understand that I have the right to revoke this authorization, at any time prior to the University Radiology Group's compliance with the request set forth herein, provided that the revocation is in writing. I further understand that additional information relating to the exceptions to the right to revoke and a description of how I may revoke this authorization is set forth in University Radiology Group's Notice of Privacy Practices. I understand that any revocation must include my name, address, telephone number, date of this authorization, my signature, and that I should send it to:

University Radiology Group
579A Cranbury Road
East Brunswick, NJ 08816
Attn: Privacy Officer

I understand that the information used or disclosed pursuant to this authorization may be subject to re-disclosure by the Recipient listed above and, in that case, will no longer be protected by HIPAA.

This authorization expires upon University Radiology Group's release of the information described above or thirty days after the Date of Authorization, as set forth below, whichever comes first.

_____ _____
Signature of Individual or Personal Representative | Patient's Date of Birth

_____ _____
Description of Personal Representative's Authority | Date of Authorization