PATIENT AUTHORIZATION FORM TO DISCLOSE PROTECTED HEALTH INFORMATION

PLEASE READ THE ENTIRE FORM BEFORE SIGNING BELOW

Patient's Name (First Middle Last): _____

Patient's Date of Birth (mm/dd/yyyy): _____

Patient's Address: _____ City: _____ State: _____ Zip: _____

You may use this form to allow your healthcare provider to disclose your health information. Your choice on whether to sign this form will not affect your ability to receive medical treatment, payment for medical treatment, or health insurance enrollment or eligibility for benefits.

By signing this form, I voluntarily authorize, give my permission, and allow the use and disclosure of my HEALTH INFORMATION (check one)

- ☐ **I authorize the release of my complete medical record, which may include information regarding my alcohol/drug abuse treatment, mental health, HIV test results and related treatment, developmental disabilities, sexually transmitted or other communicable diseases, and/or genetic information.**
- ☐ **I authorize the release of my medical record with the exception of the following information:**

_____

FROM WHOM: M.O.M. Mobile Onsite Mammography, Inc. and SMI Imaging, LLC.

TO WHOM: My new health care provider: _____

PURPOSE: For medical treatment or consultation, billing or claims payment, or other purposes as I may direct.

EFFECTIVE PERIOD: This authorization/permission form will remain in effect until my death or the day I withdraw my permission, whichever occurs first.

By signing this form, I understand that:

- I can revoke this authorization at any time by giving written notice to my new health care provider.
- I authorize the use of a copy (including electronic copy) of this form for the disclosure of the information described above.
- Information disclosed pursuant to this authorization may be re-disclosed by my new health care provider and may no longer be protected by federal privacy law.
- **I understand that refusing to sign this form does not stop disclosure of my health information that is otherwise permitted by law without my specific authorization or permission.**
- **I have read the entirety of this form and agree to the disclosures above.**

X _____ _____

Signature of Patient or Patient's Legal Representative — Date Signed (mm/dd/yyyy)

_____

Print Name of Legal Representative (if applicable)

Check one to describe the relationship of Legal Representative to Patient (if applicable):

- ☐ Parent of minor
- ☐ Guardian
- ☐ Other personal representative (explain: _____)

NOTE: You are entitled to receive a copy of this form after you sign it.