

LUBBOCK DIAGNOSTIC RADIOLOGY, L.L.P.
COVENANT DIAGNOSTIC IMAGING
LUBBOCK RADIOLOGY, L.P.
NEUROSURGICAL ASSOCIATES, L.L.P.
LUBBOCK IMAGING MANAGEMENT SERVICES, LTD

Authorization for Use and Disclosure of Private Health Information

I hereby authorize the use or disclosure of my protected health information as described below.

PATIENT NAME: _____ DATE: _____

PATIENT SS# _____ D.O.B. _____

FILM ID: _____

Specific Description of the information to be used or disclosed: _____ Date of Service: _____

Type of Exam(s) _____

Your Information may be used for the following purposes: Faxing reports, Release of films, Release of Report(s), Release of OB pictures, Viewing Records,

Other Reasons: _____

Unless otherwise requested, physicians other than your referring physician can request and receive your health information.

Name of other people allowed to request and receive my health information:

Myself _____ Spouse _____ Other Family Member _____ Care Taker _____

Friend _____ Other _____

Request for visitor to attend this visit with me and to have access to communications concerning my protected health

Information: Spouse _____ Child _____ Parent _____ Other family member _____

Care Taker _____ Friend _____ Other _____

To carry out healthcare operations, this patient has authorized Lubbock Diagnostic Radiology, L.L.P., Covenant Diagnostic Imaging, Lubbock Radiology, L.P., Neurosurgical Associates, L.L.P., or Lubbock Imaging Management Services, LTD to obtain previous medical records for comparison.

Patient Initials: _____

This authorization shall be in force and effect until the following date, at which time this authorization to use or disclose this PHI expires: 6 years _____ Other _____

I understand that I have the right to revoke this authorization at any time, in writing, by mailing such written notification to Amy Lambright at Lubbock Radiology, L.P. at 3707 21st Street, Lubbock, TX 79401. I understand that a revocation is not effective to the extent that Lubbock Diagnostic Radiology, L.L.P., Covenant Diagnostic Imaging, Lubbock Radiology, L.P., Neurosurgical Associates, L.L.P., or Lubbock Imaging Management Services, LTD has taken action in reliance on this authorization or if this authorization was obtained as a condition of obtaining insurance coverage and the law provides the Insurer with the right to contest a claim under the policy or to contest the policy itself.

I understand that Lubbock Diagnostic Radiology, L.L.P., Covenant Diagnostic Imaging, Lubbock Radiology, L.P., Neurosurgical Associates, L.L.P., or Lubbock Imaging Management Services, LTD will not condition my treatment on whether I provide authorization for the requested use or disclosure if to do so would be prohibited by federal or state law. If a reason exists under law for conditioning my treatment or obtaining this authorization I have been advised of that fact and of the consequences to me of refusing to sign this authorization.

I understand that there is a potential for information used or disclosed pursuant to this authorization to be subject to re-disclosure by the recipient and no longer be protected by federal or state law.

Signature of Patient or Personal Representative

Date

Signature of LDR, CDI, LR, NA, or LIMS Representative

Date