HIPAA Privacy Authorization Form

Authorization for Use or Disclosure of Protected Health Information
(Required by the Health Insurance Portability and Accountability Act ---- 45 CFR Parts 160 and 164) Complete only if you have had a previous mammogram

Patient Name: ____ Date of Birth: ______/______/_______

Per section 45CFR 164.506 and section 45 CFR164.501 of the HIPAA Privacy Authorization Act
I,_________________________, authorize and allow my personal PHI (personal Health Information) to be released to COVERED ENITIES as CONTINUATION OF CARE.
I,____understand that per this HIPPA SECTION a MEDICAL RELEASE does not have to be signed. I authorize ELEVATION MEDICAL IMAGING the access to disclosure of my Protected Health Information (PHI) for the purpose of BILLING,TREATMENT and PROGNOSIS .

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Signature of Patient /Legal Guardian Date

I authorize _______________________________________Relationship __________________ Phone___________ access to my medical records.

Yes, I would like access to the patient portal where I can see my Images and reports. I understand that within the patient portal I will be able to see my images and reports, as well as, send then to anyone I desire.
__________ (initial) E-mail Address: ____
No, I decline this feature. ________ (initial)

I understand that I am entitled to a copy of Elevation Medical Imaging Notice of Privacy Practices. I can access a copy of the Notice of Privacy Practices from the office directly.

I understand that I have the right to revoke this authorization, in writing, at any time. I understand that a revocation is not effective to the extent that any person or entity has already acted in reliance on my authorization or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim. Unless otherwise revoked this authorization shall be in force and effect one year from today’s date at which time this authorization expires.

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Signature of Patient Date: