RADIOLOGY ASSOCIATES OF OCALA

PATIENT AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

By signing this authorization, I authorize Radiology Associates of Ocala to use and/or disclose certain protected health information (PHI) about me for purposes of legal representation. When my information is used or disclosed pursuant to this authorization, it may be subject to re-disclosure by the recipient and may no longer be protected by the federal HIPAA Privacy Rule. I have the right to revoke this authorization in writing except to the extent that the practice has acted in reliance upon this authorization.

Additional Disclosure of PHI:

Additionally, by signing this authorization I authorize Radiology Associates of Ocala to release my PHI to the following attorney office and their staff.

RECORDS DEPOSITION SERVICE, INC., PO BOX 5054, SOUTHFIELD, MI 48086-5054, P: 248-357-3330 F: 248-357-3337

Unless restricted as described below, the individuals and/or entities listed above are allowed full and complete access to my PHI to include diagnostic reports and images:

Restrictions _____

This authorization will not expire until or unless I direct such expiration or at the onset of the below noted Defined Event _____

If I wish to revoke this authorization at a later date I understand that I must do so in writing. My written revocation must be submitted to the Privacy Officer at: PO Box 6200, Ocala, FL 34478-6200.

Under Rule 64B8-10.003, Florida Administrative Code, Radiology Associates of Ocala will charge $1.00 per page up to 25 pages, for each additional page after 25; the charge will be 25 cents per page

_____ _____

Print Patient's Name and SSN | Print Name of Legal Guardian/Personal Representative

_____ _____

Relationship to Patient | Date

_____

Signature of Patient, Legal Guardian or Personal Representative

(Please be sure to include with your request a copy of the court order appointing the legal guardian or personal representative)

_____ _____

Notary Signature and stamp | Date