Gulf Coast MRI & Diagnostic
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HIPPA Privacy Authorization Form

Authorization for Use or Disclosure of Protected Health Information
(Required by the Health Insurance Portability and Accountability Act, 45 C.F.R. Parts 160 and 164)

1. I hereby authorize Gulf Coast MRI & Diagnostic to use and/or disclose the protected health information (PHI) described below.

2. Authorization for release of PHI covering the period of health care from all past, present, and future periods.

3. I herby authorize the release of PHI as follows

   a. My complete health records (including records relating to mental health care, communicable diseases, HIV or AIDS, and treatment of alcohol/drug abuse)

4. In addition to the authorizing for release of my PHI described in paragraph 3of this authorization, I authorize disclosure of information regarding my billing, condition, treatment, and prognosis to the following individual(s)

   Name _____ Relationship_____

   Name_____ Relationship _____

5. This medical information may be used by the persons authorize to receive this information for medical treatment or consulting, billing or claims payment, or other purposes as I may direct.

6. 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 consent a claim.

7. I understand that my treatment, payment, enrollment, or eligibility for benefits will not be conditioned on whether I sign the authorization.

8. I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

Patient Signature _____ **Date** _____