



SOUTHERN ARIZONA RAD ASSOCIATES, LLC
D/B/A SIERRA VISTA DIAGNOSTICS

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AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

Patient's Legal Name: M.R. #:
Address: DOB:
City: State: Zip Code:
Primary Telephone No.: Alternate Telephone No.:

Purpose of the Requested Use or Disclosure (check one): Continuing Medical Care; At My Request;
Filing Insurance Appeal; Other:

I hereby authorize Southern Arizona Rad Associates, LLC d/b/a Sierra Vista Diagnostics ("SVD") to release to the Recipient identified below, a copy or an original of the following protected health information, including any confidential HIV/AIDS-related information, confidential communicable disease-related information, and/or information relating to any mental health and/or alcohol/drug use:

- Orders Images
Radiology Reports Films
Correspondence Other (please specify below)
Entire Record

(Other)

Recipient:
Address:
City: State: Zip Code:
Fax No.: Contact Person:

I understand that I may revoke this authorization at any time by notifying SVD in writing, except to the extent that action based on this authorization has already been taken. Unless revoked, this authorization will expire on . If no date is provided it shall automatically expire six (6) months from the date on which it is signed. I agree to allow SVD to send the information to be released by fax or electronically.

Notice: SVD may not condition treatment, payment, enrollment or eligibility for benefits on whether you sign this authorization. Information disclosed pursuant to this authorization may be subject to redisclosure by the Recipient and may no longer be protected by federal privacy laws.

Signature of Patient/Personal Representative Date

\*If you are a Personal Representative, you must provide a description of your authority to act for the patient.

Blank lines for providing authority description.

INTERNAL USE ONLY

Note: SVD's receipt of payment for records is authorized by law in certain circumstances.

Date payment received Amount received Check Cash CC
Date records sent/picked up by patient Sent By