



One Webster Avenue, Suite 307
Poughkeepsie, NY 12601
845-483-5352 FAX 845-485-3804

Authorization Form for Use and Disclosure of Protected Health Information

Patient's Full Name: _____ Date of Birth: ____/____/____

I hereby authorize: _____

(Name of provider/practice making the release)

to use and/or disclose the Protected Health Information described below to (Entity to

whom information is being released): _____

for the purpose(s) of (specify the reason that this information is being released):

Protected Health Information (Identity specific information to be released):

Dates of care included: _____ to _____

1. I understand that I may inspect or obtain a copy of the protected health information described by this authorization.
2. I understand that Radiology Associates of Poughkeepsie, PLLC will not condition treatment, payment or (if applicable) enrollment in the health plan or eligibility for benefits on my providing authorization for the requested use or disclosure AND THAT I MAY REFUSE TO SIGN THIS AUTHORIZATION.
3. I understand that I may revoke this authorization in writing at any time by delivering such written revocation to the Privacy Officer of Radiology Associates of Poughkeepsie, PLLC. I also understand that such revocation will not be effective as to the disclosure of records whose release I have previously authorized, or where other action has been taken in reliance on an authorization I have signed.
4. I understand that information used or disclosed pursuant to this authorization could be subject to re-disclosure by the recipient and, if so, may not be subject to federal or state law protecting its confidentiality.

EXPIRATION DATE OR EVENT: This authorization will expire on (date no later than one year from now) _____, or the following event:

(If no date is stated, this authorization expires six months from the date it was signed.)

COPY PROVIDED: Radiology Associates of Poughkeepsie, PLLC shall provide a copy of this signed authorization to the patient if you request. This information has been disclosed to you from records whose confidentiality is protected by federal law. Federal regulations prohibit you from making any further disclosure of it without the specific written consent of the person to whom it pertains.

New York state law requires an individual or the individual's authorized legal representative to give specific consent for the release of protected health information related to certain disease conditions. By my signature above, I authorize the release of the following information that may be included in medical information held by Radiology Associates of Poughkeepsie, PLLC including records of care and treatment for **HIV/AIDS**, records of **Mental Health** care and treatment, records of **Substance Abuse** care and treatment, records of **Genetic Testing**, records of **Sexually Transmitted Disease**

____/____/____ _____
Date Signature of individual patient or representative

Authority or relationship of representative