



AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION.

Please read carefully and complete the information on this form if you wish to proceed. All sections of this authorization must be completed before Sharp and Children's MRI Center, LLC is permitted to disclose your protected health information.

EXPLANATION: This form authorizes the use or disclosure of protected health information (PHI) in the manner described below and is voluntary. Sharp and Children's MRI Center, LLC ("scMRI") will still provide medical treatment for you if you do not sign this authorization, except under limited circumstances that are described in our Notice of Privacy Practices. Please be aware that, once your information leaves scMRI, scMRI will no longer be able to protect that information, and the recipients of your information may not be legally required to protect your information.

NOTICE TO OCCUPATIONAL MEDICINE PATIENTS: California law allows your employer to access your health records only if you authorize the disclosure in writing or for certain specific reasons such as: (1) when your employer is required to do so by law; (2) when you are involved in a lawsuit (or similar process) with your employer and your medical history is at issue; (3) when the information requested was requested or paid for by your employer; (4) when the information is required to evaluate your need for medical leave or disability-related benefits; or, (5) when it is necessary to administer your employee benefits plan. If you have questions or concerns about whether any of the above situations apply to you, notify your provider before beginning any procedure and consider notifying your employer.

AUTHORIZATION TO DISCLOSE SPECIFIC PROTECTED HEALTH INFORMATION: Federal and State laws require us to obtain specific authorization from patients to release especially sensitive information which is defined as treatment or documentation related to: (1) HIV and AIDS test results; (2) psychiatric care; and, (3) treatment for alcohol or drug abuse. Be aware that we will automatically try to exclude these types of information unless you specifically identify them for release.

RESTRICTIONS: I understand that scMRI may not further use or disclose the information described herein unless another authorization is obtained from me or unless such use or disclosure is specifically required or permitted by law. I hereby release scMRI from any/all liability that may arise from the release of this information to the party named on this form.

ADDITIONAL COPY: I understand that I have a right to receive a copy of this authorization upon my request.

DURATION: I further understand that I may revoke this authorization in writing at any time (see scMRI Notice of Privacy Practices for instructions), except to the extent that action has already been taken. Unless otherwise noted, this authorization will expire one year from the date of my signature.

CHARGES: If your PHI is being released directly to you, you may be responsible for payment of a reasonable, cost-based processing fee which covers clerical costs as well as any/all costs associated with copying of the information.

Authorization: I authorize disclosure of medical information and health records as described below:

Name of Patient: _____

Patient's Date of Birth: ____/____/____ Telephone: (____) _____

Records Released To: _____

Information to be Released (Film or CD) for these Dates of Service: From _____ To _____

Patient's Printed Name: _____

Patient's Signature: _____ Date/Time: _____

If signed by other than patient, indicate relationship to patient: _____

Witness (Print Name & Sign): _____ Date/Time: _____

Attending Physician (Required for Behavioral Health): _____ Date/Time: _____

Mail this completed form to: Sharp and Children's MRI Center, LLC, 7901 Frost Street, San Diego, CA 92123 858.939.4550 (fax) 858.939.4556