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O. (479) 571-1004
F. (479) 571-5013

AUTHORIZATION TO RELEASE HEALTH INFORMATION

I authorize the use/disclosure of my health information as described below:

1. Who is authorized to use/disclose the information:

   ____

   ____

2. Who is authorized to receive the information:

   ____

   ____

3. Description of information that may be disclosed and the dates of such information (for example, nurses notes from 01/01/01 to 01/15/01):

   ____

   ____

   ____

4. The information will be used/disclosed for the following purposes:

   ____

   ____

   ____

5. I understand that if the person or entity that receives the information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be redisclosed and no longer protected by these regulations.
6. I understand that Clearvue Medical Imaging will be paid for the costs of copying the information to be released.
7. I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment or payment or my eligibility for benefits. I may inspect or copy any information used/disclosed under this authorization.
8. I understand that I may revoke this authorization in writing at any time by delivering a copy of my revocation to Clearvue Medical Imaging except to the extent that action has been taken in reliance on this authorization. This authorization expires ninety (90) days from the date it is signed below.

________________________	____________________
Signature of Patient/Representative	Date
________________________	
Patient's Name	
________________________	____________________
Name of Personal Representative (if applicable)	Relationship to Patient
________________________	____________________
Witness	Date