Completion of this document authorizes the disclosure and/or use of individually identifiable health information, as set forth below, consistent with California and Federal law concerning the privacy of such information. **Failure to provide all information requested may invalidate this authorization. Please print and use black or blue ink.**

Patient's Name: _____ Medical Record No. _____
(Last Name) (First Name) (Middle Int.)

Date of Birth: _____ Social Security No. _____ Phone No. _____

Authorization

I hereby authorize **Emanate Health Imaging** to furnish to:

_____
(Name) (Address)

_____
(City) (State) (Zip Code) (Area Code) (Phone Number)

the following information: Please check ☐ paper or ☐ digital format on CD. Costs may apply.

☐ Complete Chart*	☑ X-ray and Imaging Reports	☐ HIV Results
☐ Resume*	☐ Lab Results*	☐ ER ONLY: Lab and/or Rad. Reports
☐ Mental Health	☐ Employee Health	☐ ST Video Recording ($10 fee)
☐ Other: _____		

*Please note this may include HIV results, as applicable

Uses

This information for which I'm authorizing disclosure will be used for the following purpose:

_____

Patient's Right

I may refuse to sign this Authorization.
I may inspect or obtain a copy of the health information that I am being asked to allow the use or disclosure of.
I may revoke this authorization at any time. My revocation must be in writing, signed by me or on my behalf, and delivered to the medical records department.
My revocation will be effective upon receipt, but will not be effective to the extent that the Requestor or others have acted in reliance upon this Authorization.
I have a right to receive a copy of this authorization.

Duration of Authorization

This authorization will expire on the following date, event or condition: _____. If I fail to specify an expiration date or event, this authorization will expire 6 months from the date on which it was signed.

Restrictions

Information disclosed pursuant to this authorization could be re-disclosed by the recipient. Such re-disclosure is in some cases not protected by California law and may no longer be protected by federal confidentiality law (HIPAA).

_____ _____ _____
Signature of patient/legal representative/spouse Date Time

_____ _____ _____
Relationship to patient (if signed by Legal Representative) Witness Date

EmanateHealth™ Imaging

AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

EHI-10101 (Rev 6-21)

Patient Information

Patient Name

Unit #

D.O.B.